			1 - For State Registrar	State of Ma	•		ment of H		Mental Hy			
	_		Hegistrar Decedent's Name (First, Middle, Last	st)		Oeru	ilcate of L	Jean	2. Date of De	Reg. No.	2004	3 Time of Dean
	Physic		Marion Eugen	,	1				Month March	Day		8:35 P M
W.	/Medi Examir		4a. Facility Name (If not institution, give		L	4	b. Citv. Town, or	Location of Death			County of Death	0.33 P
1	LXanni	iei	Frederick Memori	al Hognita	1		Freder				rederic	r
	Funeral		5. Social Security Number 6. S		(In yrs. last bin		f Under 1 Year	If Under 24 Hrs.	8. Date of Bi		9. Birthp	place (State or Foreign
	Director		218-30-7769	MM 2□F	68	Yrs.	fonths Days	Hours Min.	January	1, 19:	36	Maryland
	pu ,		Usual Residence of Decedent									
	aryla	-	10a. State 10b. County		10c. City, Towr							Od. Inside City Limits
	Be-f	Director	Maryland Frederi	ck	Fred	leric						1 ☐ Yes 2 ☒ No
	vith ti	Dir	10e. Street and Number				10f. Zip Code	_			zen of What Coul	ntry?
	s 23	Funerai	4110 Basford Road				2170				U.S.A.	4 4
	er de Item	Ę	11. Marital Status	12. Was Decedent E Armed Forces?		13. Wa	s Decedent of Hi es, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	0-	 Race - Americ Black, White, 	
36	rs aff	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 □Yes 2 No If Yes, Give Year or Dates:	,	1□	Yes 21X No	Specify:			Specify: Wh	ite
21215-0036	n 72 hours after death with the Maryland "netural", or Items 23e or 28e-f show calcal Examiner rust be notified at	ed	15. Decedent's Ed		16a.	Deceden	t's Usual Occupa	ation		16b. Kir	nd of Business/In	dustry
215	10	piet	(Specify only highest gra	de completed)		(Give kin life. DO	d of work done o NOT use retired	luring most of wor)	rking			,
21	d within giene. er then "	Completed	3	College (1-4or 54	"	Own	er/Opera	ator		В1	acktop/E	aving
	be filed ntal Hygie od other event, II	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middle	, Maiden	Sumame)	
<u> a</u>	Mental Mental Brked c	To	Clarence B. Smith					Mamie (C. Holt			
Maryland	2 shoul and Me le marl eumati		19a. Informant's Name/Relationship (7	Туре, Print)	19b.	. Mailing /	Address (Street a	and Number or Ru	ıral Route Numb	er, City or	r Town, State, Zip	Code)
	is 1 and 2 should of Health and Mer item 27 le marke other treumatic		Wanda Fike/Daught	er	10	815	Pleasant	: Walk Ro	oad, Mye	ersvi	lle, Mar	yland, 21773
Baltimore,	of He of He fiter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Bomoval from State	20b. Place of cemeter	Dispositi y, cremat	on (Name of ory or other place	θ)	Date	20c. Lo	cation - City or To	own, State
Ĕ	Pages ment of i ent: If its ury or o		`4 □ Donation 5 □ Other (Specify		Mt. Pr	ospe	ct Cemet	eryMarch	27, 2004	Lewi	istown,	Maryland
at	permit. Pages Department of the Importent: If its any Injury or of once.		21. Signature of Funeral Service Licen	see AA	,	22. N	ame and Addres	s of Facility			106 East	Church Street
ш	20 E E 9		7. Kyan 7	ME Mille	w	Keen	ey and Ba	sford P.A.	Funeral	Home	Frederick	, MD, 21701
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused to one cause on each line	he death. Do r	not enter t	he mode of dying	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Com	cer of	lu	ne					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):	1	,				
в	Lamine	_	Sequentially list conditions,	b. Meta	staris	ίγ	the	Cones	+ live	~		
	pe ti	Examiner	R and Lasting to strongdists	Due to (or as a	ponsequence o	of):		bones				
)	and tran	саш	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Chronic	clest	reci	The U	i des	ease			
60,	be ex	E E		Due to (or as a	consequence	or);						
68760,	ficate be executed physician and s the burial-transit	dicai		d								
	ding b		IF FEMALE:	23c. If yes, outcome a	f oregnancy						204 0 4 4 15	
Вох	death certif e attending id for use a:	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death		topic pregnancy			2	23d. Date of delive Month	ery Day Year
P.O.	the d	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	ina or death	200	шөг (эрөслу)					
	The law requires that the de- ate has been signed by the a page 2 should it e detached f	by Physician/M	Part II. Other significant conditions of	ontributing to death but	not resulting in	the unde	rlying cause give	en in Part I.	23e. Did	tobacco u	se contribute to t	he cause of death?
p	uires sign ld te	d b	Diabety m	ellitus					1 🗗	Yes 20	□No 3 □ Prot	pably 4 Unknown
Records,	w require been sign	Completed							24a. Was	an an	24h Were auto	ppsy findings available
Re	he fav e has ge 2	du							auto		prior to co death?	mpletion of cause of
g	Physicien: The la r this certificate has ral director, page 2	e Co	25. Was case referred to medical							2 PNo	1 🗆 Yes	2 No
of Vital	Physicien: r this certifice ral director, p	8	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	Hospital: 1 1 Inpatien	2 C E B/O	4414	2□ DOA Othe	26. Place of Dea			7 COtt (0	
o	Phy r this aral d	: To	27. Manper of Death	28a. Date of Injury	28b. T	ime of	28c. injury	4 Nuising II	28d. Describe		Other (Special of the Control of the	<u>y)</u>
0	ding I th. : After s funer	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) ir	njury	Work	(? Yes 2 □ No			•	
Division	Atter r dea ector by the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	y · At home, fai	rm, street	, factory, office		28f. Location	(Street and	d Number or Rura	al Route Number,
á	al or afte Dire	Certification:	4 Homicide determined	building, etc.	(Specify)		,.		City or To	wn, State))	
	pspit hours unere y fille		29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge	, death or	curred at the tim	e, date and place	, and due to the	cause(s)	and manner as s	tated.
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai	(Check only 2 Medical Examone)	niner: On the basis of e and manner state	examination and	d/or inves	tigation, in my op	oinion, death occu	rred at the time	, date and	place, and due t	o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	mi).			29c. License	number		29d. Date	e signed (Month,	Day, Year)
)			1	7.017			D5463	6		Marcl	h 25, 20	04
	K		30. Name and address of person who				nt)					
			Syed W. Haque, MD			Avenu	ie, Fred	erick, M	laryland	, 21	701-4509	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	20	Sante	-1 7	2			
	Registr	ar	water 6	1 4004	The state of the s	136	See Marie	201				

DHMH 17 Rev 1/200

Registrar

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2004

		í	1 - For State Registrar	State of Maryl			of Health ar of Death		jiene _{eg. No.} 2004	10003
	Physici /Medio	al	Decedent's Name (First, Middle, Lass SAMUEL NAYLO Toollin Nega (# antipatibilities alice)	R SCOTT		4h City To	wn, or Location of		th Day Yeer 25 2004 4c. County of Dea	5:35a M
	Examin Funeral	ier"	4a. Facility Name (If not institution, give Chester River 5. Social Security Number 6. S	Hospital C	yrs. last birthday)	Ches	stertown	n 4 Hrs. 8 Date of Birth	Kent 9. Bin	thplace (State or Foreign
9	Director		220-26-3490 Usual Residence of Decedent 10a. State 10b. County	X M 2□F 71	Yrs. City, Town or L			Jan 18	1933 M	arýland 10d. Inside City Limits
	the Maryla 28a-f shor	Director	MD Queen		illing		ode	1	log. Citizen of What C	1 ☐ Yes 2X No
980	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-1 show Its M. Jigal Exp. direct. Last Le molified at	by Funeral	1304 Dudley C 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	orners Rd. 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 対 No If Yes, Give Year or Dates:	in U.S. 13.	216 Was Deceden If Yes, specify 1 □ Yes 2	t of Hispanic Origi Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	U · S · A · 14. Race - Am Black, Whi Specify: V	
21215-0036	within 72 hou ane. then "nature	Completed	15. Decedent's Ec (Specify only highest gra	ducation de completed) College (1-4or 5+)	(Give		occupation done during most o retired)	of working	16b. Kind of Business	
Maryland 2	be filed ital Hygi od other event, I	To Be Co	9 17. Father's Name (First, Middle, Last) Leroy Scott		Fc	rmer		s Name (First, Middle, 1 ama Masde)]
Baltimore, Mary	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke eny injury or other traumatic QRGS.		19a. Informant's Name/Relationship (Mary Scott 20a. Method of Disposition 1 இBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	(Wife)	1304 Db. Place of Disposemetery, cre	Dud1 osition (Name matory or othe	ey Corr	or Rural Route Number ners Rd - 4 3/31/04	Millingto 20c. Location City of	21651 Prown, State
Balti	permit. Departm Importate eny inju		21. Signature of Funery Service Lice	MO	0510 d	alena 18 Wes	Funera st Cros	1 Home of s St. Gal	Stephen ena, MD.	L Schaech 21635
8760,	Physician physician and physician and physician and physician and physician street physician and phy	dical Examiner	23a Part Finer the disdase, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last	b. Due to (or as a cor Due to (or as a cor Due to (or as a cor C. Due to (or as a cor	CANCE		r gying, such as ca	ardiac or respiratory arr	951,	Approximate Interval Between Onset and Death MMTA
P.O. Box 6	The law requires that the death certific attending plate has been signed by the attending plage 2 should be detached for use as in	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pri 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic preg □ Other (speci			23d. Date of de Month	olivery Day Year
	w requires that been signed b should be deta	ed by Pł	Part II. Dther significant conditions of	CANCER	·		se given in Part I.		bacco use contribute t es 2 □ No 3 □ P	o the cause of death?
I Records,	The law reate has bee	Completed	CHRONIC OBST	RUCTIVE,	Puimo	VARY	DISEAS	autops perfor	sy prior to	
Division of Vital	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending investigation investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time of Injury					ecity)
Divisi	tal or Attending rs after death. al Director: After	Certification	3 Suicide 6 Could not b 4 Homicide determined	9 29a Place of Injury	At home, farm, st pecify)	reet, factory, o	ffice	28f. Location (S City or Town	treet and Number or Fi n, State)	lural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Exer	ysicien: To the best of my niner: On the basis of exam and manner stated.		nvestigation, in	my opinion, death	occurred at the time, d	late and place, and du	e to the cause(s)
)	T TO SO	2	29b. Signature and title of certifier 30. Name and address of person who	Mobile V	(Itam 23a) (Tyna		D 004	1587	29d. Date signed (Mon	th, Day, Year)
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's S	22 Spec		Cheste	rtown, Mi	21620	

		-	For Stete Registrar		State of	Marylan		artment artificate			and M	lental Hy	gien Reg. N	Z 111111	10	004
	Dhusisi		1. Decedent's Name (First, Mi	ddle, Last)		-						2. Date of De Month	Da	ay Yeer		e of Death
	Physicia /Medic	al	James			Sims					i a l'Eu	March		200):55A ^M
7	Examin	er	4e. Fecility Name (If not institu	tion, give s	treet and num	ber)				Location of	of Death		40	c. County of Dec		
			Montgomery 5. Social Security Number	Gen 6. Sex		Hospit . Age (In yrs.				If Under:	24 Hrs.	8. Date of Bi	rth	Montg	rthplece (Ste	ete or Foreign
	Funeral Director		723-09-7912		M 2□F	7		Months	Days	Hours	Min.	(Month, Di March			Sountry)	C
	0		Usuel Residence of Decedent			100 60	v. Town or L									le City Limits
	show	_	10a. State 10b. Cou													Yes 2 No
	28a-f	ecto	Md • I	• .G .			SIIVE	r Sp.		3			10g. C	itizen of What C	ountry?	
:	Milh Be or	١	2601 Bel Pi	e Ro	ad				090	6				ted St		
	n 72 hours aller death with the Maryland "nature!", or Itams 23a or 28a-f show edical Exactions must be notified at	Funeral Director	11. Marital Status	1	12. Was Deced	dent Ever in U	.S. 13	Was Deced	ient of H	ispanic Ori	gin? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race - Am Bleck, Wh		n,
9	or Ita		1 ☐ Never Married 2 🗵 N		1 Tes	2X No		1 Yes :		Specify:		riioari, dio.,		0		
21215-0036	ure!',	d by	3 Widowed 4 Divor		Year or Da	tes:	160 Das	edent's Usua	1 Occup	ation			16h	Kind of Busines	lack	
15	2 48	Completed	(Specify only high		completed)		(Giv	e kind of woi DO NOT us	rk done d	during mos	t of work	ing	100.	TRITO OF BUSINESS	anidustry.	
:12	r than	шо	Elementary/Secondary (0-1	2)	College (1-	4or 5+)	S	anita	tio	n				Privat	:e	
	other other	Be C	17. Father's Name (First, Mide	ile, Last)				-		18. Mothe	er's Name	(First, Middle	, Maide	n Sumame)		
/lar		10 1	James Sim	s Sr	•		_					Thomps				
	and and le m		19a. informant's Name/Relati		oe, Print)		19b. Mai	ling Address D • Bo	(Street a	and Numbe 01	er or Aura	al Route Numi	oer, City	or Town, State,	Zip Code)	
	f Health if Health item 27 other tr		James Sims 20a Method of Disposition	/son		20b. F	Ca Place of Disc	rlist position (Nan	e, ne of	S.C.	29	031 Date	20c. l	Location - City o	r Town, Ster	te
	Sec 10		1 Burial 2 □ Cremati		emoval from S	1 ,	semetery, cr	ematory or o	ther plac		· / ·	2/12/				
Hin			'4 □Donation 5 □ Other		96	SC.		22. Name an						Carli Edward		
Ba	permit. Depertm Imports any inju		Amile)	9/11	vand	11	3	910 8	Silv	er E	1i11	Rd.,	Su	itland	,Md.	20746
			23a. Part1. Enter the disease shock, or heart failure.	, or compli	cations that ca	used the deat	h. Do not e	nter the mod	e of dyin	g, such as	cardiac	or respiratory	arrest,			l Between
	Physician		tmmediete Cause (Final disease or condition	List only or	D85	RIC	AV	RY	(AS	110	390			Onset	and Death
	/Medical Examiner		resulting in death)		Due to (or as a consec				~			-			
생)	Examiner	Į.	Sequentially list conditions,	b	045	or as a consec		CAC	V	W 8	0	NOW	16		De	71.2.
7	nsit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺	C	C = C	1 (25)	00	ar	-114						
K -	be executed sicien and burial-transit	Exar	that initiated events resulting in death) Last	٥	Due to (or as a consec	quence of):			8 - 1						
6876	death centificate be executed e attending physicien and nd for use as the burial-transit	icai		L.	1											
99	ng ph as th		IF FEMALE:													
Вох	eath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	2		rth 2 ☐ Feta	il death 3	□Ectopic pi		,			Ì	23d. Date of di Month	elivery Day	Year
		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregna 9☐Unkno	ant at time of o wn	seath 5	Other (sp	овспу) <u> </u>							
ď	The law requires that the dite has been signed by the bage 2 should be detached	Ph.	Part II. Other significant con	ditions cor	ntributing to de	ath but not res	ulting in the	underlying c	ause giv	en in Part I	1.	23e. Did	tobacco	use contribute	to the cause	of death?
ds,	uires 1 sign 11d be	d by										1 🗆	Yes	2 □ No 3 □ F	robably 4	4 Donknown
Record	s been s should	Completed										24a. Wa		24b. Were	autopsy findi	ings available
Re	The law ate has page 2	E O											opsy formed? 2 2 1	death?	s 2 No	
		BeC	25. Was case referred to me examiner?	dical						26. Place	e of Deat	h (Check only			- 77	
of V	S S S	2	1 ☐ Yes 2 ☐ No	1-	-		ER/Outpati			4 🗆 N	ursing Ho			6 ☐Other (Sp	ecify)	
ou c	ding Ph h. After th funeral	ion:	27. Manner of Death 1 Natural 5 ☐ Pe		28a. Date of	h, Day Yeer)	28b. Time Injury	of A	28c. Injur Wor	yat k? Yes 2.□	No	28d. Describe	now inj	jury occurred		
Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 Suicide 6 □ Co	estigation uld not be	28e. Place	of Injury - At h	ome, farm.		-	163 2	1110	28f. Location	(Street a	and Number or I	Rural Route	Number,
DΪ	after after Direct	ertil	4 Homicide de	termined	buildir	ng, etc. (Speci	fy)		,,			City or To	own, Sta	ite)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		29a. Certifier 1 Cert	ifying Phy	sician: To the	best of my kn	owledge, de	ath occurred	at the tir	ne, date ar	nd place,	and due to the	e cause((s) and manner	as steted.	150(0)
	he Ho in 24 he Fu pletel	edical	(Check only 2 Med	cal Exami	and mann	er stated.	ation and/or				atti occui	red at the time		nd place, and du		
	To the within To the	Σ	29b. Signature and this of ce	Althor	1	7		290	c. Licens	e number			29d. D	ate signed (Mo	nth, Day, Ye	ar)
			- Como	36	mess	× m	(1)		X	755	200	(3-1	0	07
			30 Na and dress of per	son who co	ompleted caus	e of death (Ite	m 23a) (Typ	e, Print)	200	260) E 16	251	1>	000	アイル	5280E
1	∦ St	ate	31. Date filed (Month, Day, Y	ear)	32. R	egistrar's Sign	ature	2.0	V //	, ,	2 2-4	200	1,000	<u> </u>		
	Regist		Was I	31	2001	1	100	-0403W	1000	-						

		•	For Stete Registrar	State of	Maryland /	Depa Cea	artment of rtificate of	Health a	nd Mer		iene20	04	10005
34			1. Decedent's Name (First, Middle,	Last)		-			2.	Date of Deat Month	h Day	Year	3. Time of Death
100	Physici /Medio		John J. Tarafas	3						farch 1	1, 200		4:00 A ^M
	Examin		4a. Facility Name (If not institution, g	rive street and numb	er)		4b. City, Town,	or Location of	Death		4c. County	of Death	
			Holy Cross Reha	bilitatio	n	ا در مامر دامش	Silve	r Sprin		Date of Birth	Mont	gome	ry
	Funeral			.Sex 7. 1∭2 M 2 □ F	Age (In yrs. last b	Yrs.	Months Days		Min.	(Month, Day,			place (State or Foreign intry)
and "	Director		213-20-6964 Usual Residence of Decedent		86					ec 21,	191/	Pe	nnsylvania
	show		10a. State 10b. County		10c. City, To	wn or Lo	ocation						10d. Inside City Limits
	Mar Mar	tor	Maryland Princ	e Georges	Mt.	Ra:	inier						1 K Yes 2 □ No
	or 28	Oire	10e. Street and Number				10f. Zip Code			11	0g. Citizen of	What Cou	intry?
	23a	Funeral Director	4402 32nd St					712			USA		
	tems	nne	11. Marital Status	12. Was Deced	es?	13.	Was Decedent of If Yes, specify Cu	Hispanic Origi ban, Mexican,	in? (Specify Puerto Rica	y Yes or No- an, etc.)		ce - Amen	ican Indian, , etc.
36	rs aft	by F	1 ☐ Never Married 2XX Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ff Yes, Give Year or Date			1 □ Yes 2 汉 No	Specify:			Specif		hite
21215-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f show deal Examinat munt be notified at	ed	15. Decedent's	Education		a. Dece	dent's Usual Occi	pation			16b. Kind of B		
15	n na	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) Coffege (1-4	lor 5+)	(Give	kind of work don DO NOT use retir	e during most : ed)	of working				
212	d with	E	Elementary/Secondary (0-12)	2	101 34)	S	tatistic	ian			Dept.	of	Labor
br	al Hyg	Be	17. Father's Name (First, Middle, La	ist)				18. Mother	r's Name (F.	irst, Middle, M	Aaiden Sumar	ne)	
/lai	Ments Ments prked	70	Joseph Tarafas					Soph	nie Ko	llar			
Maryland	2 sho and I Is ma		19a. Informant's Name/Relationship	(Type, Print)	19	b. Maili	ng Address (Stree	et and Number	r or Rural R	oute Number.	. City or Town	. State, Zi	ip Code)
≥, ≤	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menfal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any joingr or other traumatic event, the Medical Examinational be notified at any joingr or other traumatic event, the Medical Examinational Denotified at any joingr or other traumatic event.		John M. Tarafas	s/Son			7 Thistlesition (Name of	ewood I	Ter. E				
ore	T E E		20a. Method of Disposition 1X Burial 2 □ Cremation 3	Removal from St	comet	ery, cre	matory or other pi				20c. Location	•	
Baltimore,	tant:		`4 □ Donation 5 □ Other (Spe		Gate		Heaven C						pring, MD
3ali	Depar Impor Impor eny in		21. Signature of Funeral Service Li	censee	110		2. Name and Add						
	40 = 64		23a. Part1. Enter the disease, or co	CARA	and the death. Di							prin	g, MD 20904 Approximate
I	Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on the	reatic ca			ang, such as o	Sardiac of Te	opinatory arre	331,		Interval Between Onset and Death 8 mos.
	/Medical Examiner		resulting in death)		r as a consequenc								
	LAdiffiller	e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or	r as a consequenc	e 01).						-	
	ted nsit	ulue	cause. Enter Underlying	D00 to (0)	as a consequenc	0 017.							
	ate be executed hysician and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or	r as a consequenc	e of):							
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687	ficate p phys s the			0.									
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	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnai	th 2 Fetal dea nt at time of death		⊒Ectopic pregnan ⊒ Other <i>(specify)</i>				Me	onth	Day Year
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ď.		y P	Part II. Other significant condition		-	•	, -	iven in Part I.					the cause of death?
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Ř		Completed by								perfòrr 1 □ Yes 2	ned?	death?	2□ No
of Vital Records,	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?						of Death (C	heck only on	e)		
× ×	Physician: this certific ral director,	ို	1 ☐ Yes 2 🔀 No		patient 2 ER/0	_	III JU DOA				ence 6 Ott		ify)
ū	ng fter inel	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month)	Day Year) 28b	. Time o	W		- 1	I. Describe ho	ow infury occur	rred	
Division	ttendi death. ctor: A / the fu	Certification;	2 Accident investiga 3 Suicide 6 Could no	t bo	A taluar At bases	fa		⊒Yes 2□N	-	Location /St	troat and Mum	bor or Ou	ral Route Number,
Ξ	after of Direct Direct din by	rtiff	4 Homicide determin	ed 28e. Place o	f Injury - At home, g, etc. (Specify)	iarm, st	reet, factory, offic	9	201.	City or Town	, State)	oer or nur	al Addie Mulliper,
]	Vo the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi			Physician: To the b									
	he Hk in 24 he Fu	edical	(Check only 2 Medical E.	xaminer: On the bas and manne		and/or ir	evestigation, in my	opinion, death	n occurred :				
	within comp	N	29b. Signal dreamd title of certifier	0/			29c. Lice	nse number		2	9d. Date signe	d (Month	, Day, Year)
) /			I the hele	Sher			D22	2780		-	3-12	2-04	
5	>		30. Name and address of person w					11	14 100	20770			,
			Peter M. Schies			eenw	ay Ct. (reenbe	TT MD	20770			
*.	St. Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 5 2	004 32.Re	gistrar's Signature	9	Spark.	1					

State of Maryland / Department of Health and Mental Hygiene 00 1 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month MAR A M **Physician** ESTHER TIDD 2004 12:28 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Days **Funeral** Months Hours 1 ☐ M 2 💆 F Yrs 87 03/07/1917 California Director 535-38-8073 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 21 No Directo Virginia Fairfax Alexandria 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 22309 , or items 23a 8407 Orinda Court by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or ite any injury or other treumatic event, the Medical Espansia 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Housewife 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles McCarty Effie May Burner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8407 Orinda Ct. Alexandria, Virginia 22309 Leon Tidd -son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 3/12/2004 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Advent Funeral Service 21. Signature of Funeral Service Licenses >My belus 7211 Lee Hwy. Falls Church, Virginia 22046 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final CARDIOVASCULAR COLLAPSE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by been signe should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 Knpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA Medical Certification; To s after death.

I Director: After this od in by the funeral d 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MAR 08, 2104 MD 0101235128 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 AUDREY G. BOLANOWSKI LTMC USN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 15 Registrar

	1	For State Registrar	State of Maryland		artment of H			ene g. No. 2004	10007
3		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
Physicia		Clarence	Carl Teubne	r			March	24 2004	2322 P M
/Medica	_	a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Deat	h	4c. County of Deat	h
		Singerly Manor			Elkton	1 22 1 217		Cecil	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 9. Birt	hplace (State or Foreign nuntry)
Director	L	283-07-5353	90	Yrs.			OCT 25,	1913 Oh	10
and	-	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
Maryl f sho	ក្ត	Maryland Cecil	E	lkton					1 ☐ Yes 2 No
128e	\sim	10e. Street and Number		Liteon	10f. Zip Code		10	g. Citizen of What Co	ountry?
3a or		24 Darlise Court			21921		,	United St	tates
ms 2	Funeral		2. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - Ame Black, Whit	
after after mirre		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 X No		1 □ Yes 2 X No	Specify:	,	Specify:	
ours 033	d by	3 X Widowed 4 Divorced	If Yes, Give Year or Dates:					WI	nite
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther then "netural", or Items 23a or 28e-1 show ant. Ite Marical Exemples must be retified at	Completed	15. Decedent's Education (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most of wo		6b. Kind of Business	industry
the within	d L	Elementary/Secondary (0-12)	College (1-4or 5+)		dscape Ga			Horticul	ture
Hygie D.	ပ္သို	12 17. Father's Name (First, Middle, Last)		Lan	uscape Go		me (First, Middle, M		carc
Maryland nd 2 should be file lith and Mental Hy 27 Is marked other r treumatic event	To Be	Herman H. Teubner				Anna K	. Althans		
shoul Me Mark	F	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Street	and Number or R	ural Route Number,	City or Town, State,	Zip Code)
Mg 2 nd 2 stranger 127 is		Wayne Teubner/Son		8128	Rose Hav	en Road,	Baltimor	e, Maryla	nd 21237
is 1 and 2 of Health item 27 I	1	20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of matory or other place anor	(e) Marc	Date 27,	20c. Location - City or	Town, State
Pages nent of t		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	Men	ipin M Morial	anor Park	2004		Elkton, Ma	ryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural; or Items 23a or 28e-1 show eny injury or other treumatic event, the Marical Examinat must be notified at once.	1	21. Signature of Funeral Service License		2: H	2. Name and Addre	ss of Facility	erals, P.	Α.	
o 88558		Ind to	4.	110	03 W. Sto	ckton St	reet, Elk	ton, Mary	
		23a. Part1. Enter the disease, or complice shock or heart failure. List only on	ations that caused the deat cause on each line.	h. Do not en	ter the mode of dyir	ng, such a <i>s</i> cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
Priysician	1 14	Immediate Cause (Final disease or condition	Respira	tory	Faily				
/Medical Examiner		resulting in death)	Due to (fir as a conseq	uence of):				120	3 Uno
LAMINICI	_	Sequentially list conditions, b.	Due to (or as a conseq	yence off:	PINAM	VY PAC	urnon	10	3 months
De isi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dusa han	in					4 months
60, Control of executed ician and purial-transit	xar	that initiated events c. resulting in death) Last	Due to or as a conseq	uence of):					
8760, cate be executed hysician and the burial-transit	lical E	l a							
Box 687 death certificate e attending phys of for use as the	edic			THE STATE OF THE S		-		- 1	
Box 68 eath certifica attending ph	Physician/Med	23b. Was decedent pregnant	lc. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic pregnanc	v		23d. Date of de Month	livery Day Year
	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of o		Other (specify)			Width	Duy . ou.
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S, F res tha igned be de	by	Part II. Other significent conditions con	thouting to death but not res	Called the C	indenying cause gi	on mean.	1 □ Ye	Vi	robably 4 □Unknown
cord w requir been si	ted	1 1.) C. M.	1.014	11111 (1)				
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Phy rald	. To	1 ☐ Yes 2 💢 No	28a. Date of Injury	28b. Time o	of 28c. Inju	ry at	,	w injury occurred	Hair
On ding	tlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk?]Yes 2 □No			
Division If or Attending after death. Director: After din by the funer	fica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, larm, s	treet, factory, office		28f. Location (St. City or Town	reet and Number or R	ural Route Number,
Div al or al Dire	Certification:	4 Homicide	building, etc. (Space	·y)					
Divisit To the Hospital or Interviewithin 24 hours after deeth To the Funeral Director: completely filled in by the	edical (29a. Certifier Certifying Phys	ician: To the best of my known.	owledge, dea	th occurred at the to	ime, date and place opinion, death occ	e, and due to the ca	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
the H in 24 the F	ledi	one)	and manner stated.		29c. Licen			9d. Date signed (Mon	
Viit To	Σ	29b. Signature and title of certifier	1		250, Licen	10077			/ /
,			~ (m		DU	7470		arch 26	
6		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type ムーム	St DII	H 314	Elf tin	MP 21	1921
Sta	ato	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	11, 501	() ()	0/2/011,	/// 0/	1021
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			For State	State of Maryland	-	rtment of		d Mental Hy	•	2001	Innno
			Registrar Decedent's Neme (First, Middle, La	ist)	0071	imodio oi	Deam	2. Date of D	Reg. No.	200-	3. Time of Death
H	Physici		Edoor	,	1	largas		Month	Day	Year 2005	11117 M
-	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town,	or Location of De			County of Deeth	
	LXUIIII		The Johns Hor	oking Hospin	1	Baltin	MADO CO	1.40			
	Funeral	-		Sex 7. Age (In yrs. las	st birthday)	If Under 1 Yea			rth	9. Birth	place (State or Foreign
١.	Director		none	1 X]M 2□F	Yrs.	Months Day:	s Hours M	1 / 0 9 /	200	4 Ball	timore, MD
	D >		Usual Residence of Decedent 10a. State 10b. County	10- 6	T						
	aryla shov	7	MD Montgo		Town or Loc	spring					10d. Inside City Limits 1 ☐ Yes 2X No
	286-1	Director	10e. Street and Number	MC1 y D11	LVCI						
	death with the Maryland ms 23a or 28e-f show r.must be notified at	ă	8219 14th Aver	uio Ant 201		10f. Zip Code 2090	2			zen of What Co	intry?
	eath	Funerai	11. Marital Status	12. Was Decedent Ever in U.S.	13 W	1		(Specify Ves or N		SA 14. Race - Amer	ican Indian
	iter d	Fun	1X Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 X No				(Specify Yes or Ni lerto Rican, etc.)		Black, White	
15-0036	within 72 hours after death with the Marylan ene. than "natural", or items 23a or 28e-1 show the Medical Examinar must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1-	Yes 2□N	Specify: HC	onduras		Specify: W	nite
Š	"natural",	Completed	15. Decedent's E		16a. Decede	ent's Usual Occ	upation		16b. Ki	nd of Business/I	ndustry
Z	thin 7	pje.	(Specify only highest gi	College (1-4or 5+)	life. D	O NOT use retir	e during most of (ed)	working			
7	ed wi	Co	0			none				none	
and	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, Las	0			18. Mother's N	Name (First, Middle	, Maiden	Sumame)	
S	should by and Menta marked matic ev	၉	Carlos Gomez				Nanc	y Varga	s		
Mar	2 g = 9	10 =	19a. Informant's Name/Relationship					Rural Route Numb			
-	1 and 1ealth sm 27 ther ti	-83	Carlos Gomez/F		8219	14th	Ave. #2	01 Silv	er S	pring,	Md 20903
وّ			1 🗷 Burial 2 □ Cremation 3 (Removal from State	netery, crem	atory or other pl				cation - City or T	
altimore,	Department Mportant: mportant: nny injury o	1	*4 □ Donation 5 □ Other (Special Signatur of Funeral Service Live	7.	.e 01	HEave		2/04			ring,MD/
ga	permit. Pege Department of Important: If any injury of once.		Mily & Lu	John	92	241 Co.	J.RTNAL Lumbia	DI FUNE BIVd.Si	RAL lver	SERVIC Sprin	E, P.A. 1g, Md20910
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	iplications that caused the death. one cause on each line.	Do not ente						Approximate Interval Between
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	/Medical Examiner		resulting in death)	a. Klebsiella : Due to (or as a consequent	ence of):						
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	xecu a and al-trai	хаг	that initiated events resulting in death) Last	c. Incarcerate Due to (or as a consequer	ince ot):	ngvina	. I Merri	1100			4 days
9/8	cate be executed physician and the burial-transit			o. Extreme p	orema	turity	1				2 months
9	ificate g phy as the	Physician/Medical	1500	0		J					
XOD	w requires that the death certificate been signed by the attending the should be detached for use as	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnanc					2	23d. Date of deliv	rery
	death e att	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetel de 4 ☐ Pregnant at time of deat		Ectopic pregnan Other <i>(specify)</i>	су			Month	Day Year
r O	at the by the	hys	9 🗆 Unknown	9□ Unknown							
	requires that een signed b hould be deta	by	Part II. Other significant conditions	contributing to death but not resulti	ing in the und	derlying cause g	iven in Part I.				the cause of death?
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	sicien: The law certificate has t irector, page 2 s	Con						perfo 1 X Yes	rmed?	death?	
VITAI	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Death (Check only		-	
ō	this ald	. To	1 ☐ Yes 2 2 No 27. Manner of Death	1) Xinpatient 2 En	R/Outpatient 8b. Time of	3 DOA	4 Nursing	Home 5 Resi			fy)
<u> </u>	ding h. After fune	tion	1 ⊠Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Inju	ork? ☐Yes 2☐No	28d. Describe	now injury	occurred	
JIVISION	r Attending P er death. rector: After i by the funera	ertification:	3 Suicide 6 Could not t	28e. Place of Injury - At home	ie, tarm, stree			28f. Location (Street and	d Number or Rur	al Route Number.
É	spitel or ours after ours after ours filled in the	Certi	4 Homicide determined	building, etc. (Specify)				City or To	wn, State)		
	Hos Fur ely	Medical	29a. Certifier (Check only one) 1 ★ Certifying P 2 ★ Medical Exa	hysician: To the best of my knowle miner: On the basis of examination and manner stated.	edge, death in and/or inve	occurred at the satigation, in my	time, date and pla opinion, death oc	ace, and due to the courred at the time,	cause(s) date and	and manner as s place, and due t	stated. o the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier			29c. Licer	se number		29d. Date	signed (Month,	Day, Year)
			Unne-Api	O Sohan M.D.		D005	6086		Mari	n 9	2004
		1	30. Name and address of person wh	compyted course of death (Item 2)	23a) (Type, P	rint)			,,		
				chay 600 North	h Wolfe	· Street,	Baltima	re Mary	land	212	87
k .	Sta Registr		31. Date tiled (Month, Day, Year) MAR 1 7 2	Long Loo North 32. Registrar's Signatur	5	Spark	2	, 0			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Manyland / Department of Health and Mental Hygiene

Physici	an	1. Decedent's Name (First, Middle, Last) BEATRICE CO	LES WILKE	RSON		2. Date of De. Month MARCH 2	Day Yee	3. Time of Death 11:10 P
/Medic		4a. Facility Name (If not institution, give s Prince George's Re			ity, Town, or Location of Cheverly		4c. County of De	ath
Funeral Director		5, Social Security Number 6. Sex		last birthday) If Ur Yrs. Mont	nder 1 Year If Under 24 hs Days Hours	4 Hrs. 8. Date of Bird Min. 08/24/1	9. B 920 Vii	irthplace (State or Fore Country) ginia
Aaryland show	or	Usual Residence of Decedent 10a. State 10b. County Virginia Pittsylva		y, Town or Location				10d. Inside City Lim
with the h	I Director	10e. Street and Number 4800 Markham Road			Zip Code 24565		10g. Citizen of What (Country?
172 hours alter death with the Maryland "natural", or Items 23e or 28e-f show rolcal Examiner must be neitified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates:		ecedent of Hispanic Origi specify Cuban, Mexican, s 2 XNo Specify:	in? (Specify Yes or No Puerto Rican, etc.)	14. Race - An Black, Wh Specify: B]	
within 72 ho lene. than "natur ina Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation s <i>completed)</i> College (1-4or 5+)	16a. Decedent's l (Give kind of life. DO NO Housek	f work done during most o T use retired)	of working	16b. Kind of Busines	
tal Hyg d other	To Be Co	12 17. Father's Name (First, Middle, Last) James Coles		Troubert	18. Mother	's Name (First, Middle,	Maiden Sumame)	
nd z snould ith and Men 27 is marke r traumatic	-	19a. Informant's Name/Relationship (Type Osie Wilkerson			ress (Street and Number RKHAM ROAD,			, Zip Code)
rages I and sent of Health ut: If Item 27 iry or other tr		20a. Method of Disposition 1	emoval from State	Place of Disposition cometery, crematory eville Ba	Name of or other place) ptist Church	Date h 3/9/2004	20c. Location - City of	
Department Important: I any injury once.	ļ	21. Signature of Funeral Service License Karen Wooddell		22 Nam Mill Gret	er Funeral Ina, VA 2455	Home, P.O.	Box 423,	
Physician /Medical bysician and /medical sthe parial-transit	edical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Drie to for as a consect Aspirate	Shock (uence of): (uence of): (uence of):	lure egally			dup Aug Aug
e attending od for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No 9 \(\text{Unknown} \) Unknown	3c. If yes, outcome of pregnia 1 Live birth 2 Feta 4 Pregnant at time of d	al death 3 Ectop	ic pregnancy r (specify)		23d. Date of c	lelivery Day Year
wheelings that the should be detached		Part H. Other significant conditions cor	ntnbuting to death but not res	sulting in the underlyi	ng cause given in Part I.		obacco use contribute Yes 2 □ No 3 □	to the cause of death
2 0	Completed by	Shypergyemin				24a. Was auto perio 1 🗆 Yes	osy prior t ormed? death	autopsy findings avail o completion of cause ? es 22 No
rnysician: The lavitus certificate has ral director, page 2	To Be (1 Yes 2 No			DOA Other: 4 Nur	of Death (Check only of Sing Home 5 - Resi	dence 6 □Other (S)	oecify)
To the Hospital or Attending Privally within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Natural 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Specification)		28c. Injury at Work? 1 □ Yes 2 □ N ctory, office	lo	how injury occurred Street and Number or wn, State)	Rural Route Number,
nospital 24 hours a Funeral I tely filled	edical Ce		sician: To the best of my kno ner: On the basis of examina and manner stated.					
• " • •	Me	29b. Signature and tale of certifier			29c. License number		29d. Date signed (Mo	nth. Dev. Year)

1

			For State Registrar	State	of Marylar		artment <i>rtificate</i>			nd Me		iene,	2004	10010
6	Physici		Decedent's Name (First, Middle Doreen Ma		r						Date of Death Month March 1		2004 ^{Year}	3. Time of Death 10:55 a M
	/Medio		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, 7	Town, or	Location of D			T	County of Death	
			Mariner Health					thes				Mo	ontgome	
	Funeral Director		5. Social Security Number 219-46-7109	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 68	last birthday) Yrs.	Months	Days	If Under 24 Hours	Min.	Date of Birth (Month, Dey,		Cou	place (State or Foreign ntry) 1and
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits
	Mary I sho	to	Maryland Mont	gomery	Į,	Kensing	ton							1 ☐ Yes 2 ☑ No
	th the	lrec	10e. Street and Number	B002			10f. Zip	Code			10	g. Citize	en of What Cou	ntry?
	ath w	ral	3004 Ferndale						895				USA	
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Internet: I term 27 is marked other than "natural, or liems 23e or 28e-1 show any injury or other traumatic event, the Modical Examiner must be notified at once.	Funeral Director	11. Marital Status 1 Never Married 2 Marr	Armed F	2 🛛 No		Was Decede If Yes, spec 1 ☐ Yes 2		spanic Origin' n, Mexican, P Specify:	? (Specif Puerto Ric	fy Yes or No- can, etc.)		4. Race - Ameri Black, White,	etc.
0000	ural',	d by	3 Widowed 4 Divorced	Year or	Dates:								Specify: Whit	
<u>.</u>	in 72 n "nat Nadici	Completed	15. Deceden (Specify only higher	st grade completed		16a. Dece (Give	dent's Usua kind of won DO NOT us	l Occupa k done d e retired,	ition Tu <i>ring m</i> ost of)	f working		l6b. Kind	d of Business/Ir	dustry
7 7	d with giene.	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)	Wa	aitres	s				Foc	od Servi	Lce
	oe file tal Hyg d othe	Be C	17. Father's Name (First, Middle,	,							First, Middle, N			
<u> </u>	Menid I	ပ	Unknov					10:			Barratt			
20	d 2 st th and th snc 7 ls n traun		19a. Informant's Name/Relations										Town, State, Zij	ŕ
บ์	1 and Heal		Amelia Phillips 20a. Method of Disposition	s/ Filend	20b.	Place of Dispo	sition (Nam	e of		Date	7.70		MD 208 ation - City or To	
Ē	Page national ry or		1 ☐ Burial 2 🖾 Cremation 1 ☐ Donation 5 ☐ Other (S		n State	tropo11	•			2004		Alex	andria,	Virginia
pannore	apartin sporte y inju		21. Signature of Funeral Se, ice	igensee	A18 1 12%					e Fu	neral I			J
0	80 5 5 9		powerf /	Ja-	/	50	0 Un:	iver	sity B	lvd.	W., Si	lver	Spring	
			234. Part. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea each line.	th. Do not ent	er the mode	of dying), such as car	rdiac or r	espiratory arre	st,		Approximate Interval Between Onset and Death
B.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	static		oma (1	No P	rimary)				
	Examiner				o (or as a consec	quence or):								
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to	(or as a consec	quence of).								
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to	o (or as a consec	ruanco of):								
0/00,	cate be executed physician and the burial-transit	alE			O (OI as a COIISGC	querice or).								
000	flicate g phys	edical		d										
Š	th cert ending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		DEctopic pre	annancv				23	d. Date of delive	*
	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		gnant at time of o		Other (spe						Month	Day Year
ŗ.	that the oder of detaction		Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did tob	acco use	e contribute to t	he cause of death?
cords,	w requires that s been signed t should be det	Completed by	Anemia, Seizu	re Disord	ler					_	1 ☐ Ye	s 2 🗆	No 3 ☐ Prot	pably 4 ⊠Unknown
2	ne law re has bee ye 2 sho	plet									24a. Was an		24b. Were auto	ppsy findings available mpletion of cause of
	The The page	Com									perform 1 Yes 2	ed?	death?	2 □ No
ומ	ician: sertific ector.	Be	25. Was case referred to medical examiner?	Hospital				0.1		Death (0	Check only one)		
5	Physical direction	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death			ER/Outpatier			4 LX NUISI		5 Resider		Other (Specif	y)
5	ading th. : After	tlon	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investig		e of Injury onth, Day Year)	Injury	м	3c. Injury Work 1 □ Y	? ′es 2 □ No		2. 5030100 1101	in injury	00001160	
21212	or Atter	Certification:	3 Suicide 6 Could determ	100d 286. Plac	ce of Injury - At h ding, etc. (Speci	ome, farm, str fy)	eet, factory,	office		28f	. Location (Str. City or Town,		Number or Rura	al Route Number,
-	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical Ce	(Check only 2 Medical	g Physician: To the	ne best of my kno	owledge, death	h occurred a	it the tim	e, date and pl	lace, and	due to the car	use(s) a	nd manner as s	tated.
	thin 2- the I	Med	one) 29b. Signature and title of certifie	and ma	nner stated.			License					signed (Month,	
	1	_	Digital of all the or certifie	411	_ /	70	230.	d20.			29			
	6		30. Name and address of person	who completed car	use of death (Iter	n 23a) (Type.	Print)	uZU.	710			Mal	rch 14,	2004
			Joel R.	Schulmar				Lve 1	Blvd. #	#300	, Rockv	1116	e, MD 20	0855
	Sta		31. Date (Jed (Month, Day, Year)	32.	Registrar's Signa	ature /		nek						
	Registr	ar	MAND 15	/11114	San Jugar	1-	//							

	AMEND #	Sta 29dper MD3/18/04,BMW,MbCo	te of Maryland		ment of F ficate of			2004	10011
	Physician	Decedent's Name (First, Middle, Last) Chan	rles W. Wie	cking			2. Date of Dea Month March	Day Year	3. Time of Death 8:30 AM
	/Medical	4a Facility Name (If not institution, give street a		CKIIIg		lb. City, Town, or L			
	Examiner	Montgomery Hos	oice Casev l	House		Rockv	1110	Mont	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~
		5. Social Security Number 6. Sex	7. Age (In yrs. les		If Under 1 Year				gomery
	Funeral Director	308-24-3633 ^{1፟} ፟™ ² [fonths Days	Hours Min.	8. Date of Birtl (Month, Day February		hplace (State or Foreign Juntry) Indiana
	bu k	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Locat	ion				10d. Inside City Limits
	Aaryl r sho	1 1 1			_				1 □ Yes 2 No
	the the tree the tree tree tree tree tre	Maryland Montgome 1 10e. Street and Number	ry		10f. Zip Code	Bethesda		10g. Citizen of What Co	ountry?
	Vith Di		0			00017			•
	era era	7215 Marbury 11. Marital Status 12. Wa	s Decedent Ever in U.S.	13. Wa	s Decedent of H	20817 ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No-	United 14. Race - Ame	States rican Indian,
0200-612	within 72 hours after death with the Maryland than "natural", or items 23e or 28e-f show he Medical Exercinet must be notified at ompleted by Funeral Director	1 Never Married 2 Married 1 K	ned Forces? Yes 2 □ No es, Give ar or Dates: WW II	1□	es, specify Cuba Yes 2ሺ No		Rican, etc.)	Black, Whit	e, etc. White
٦ ک	be filed within 72 hours a filed within 72 hours a d other than "natural", o svent, the Medical Examble Completed by	15. Decedent's Education	1	16a. Deceden	t's Usual Occup	ation	ina	16b. Kind of Business	
5	n n n	(Specify only highest grede comp Elementary/Secondary (0-12) Col	leted) lege (1-4or 5+)	life. DO	NOT use retired	during most of work ()	ing		
. V	d with a spin of the spin of t	20.00.00.00.00.00.00.00.00.00.00.00.00.0	5+		Econom	ist		Federal	Government
ַפ	be filed within the Hygiene. d other then event, the Mean	17. Father's Name (First, Middle, Last)	•			18. Mother's Name	e (First, Middle,	Maiden Sumame)	
Maryland	D # 8 0	Frederick	A. Wiecking	g			Mari	e White	
a a	2 shoul i end M is mark raumati	19a. Informant's Name/Relationship (Type, Prin	nt)	19b. Mailing	Address (Street	and Number or Run	al Route Numbe	r, City or Town, Stete, 2	Zip Code)
_	D = N =	Nancy H. Wiecking/ Wif	Te .	7215 N	larbury	Court Bet	thesda,	Maryland 2	0817
∞ .		20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 □ Remova	20b. Plac	ce of Dispositi	on (Neme of ory or other plac	e)	Date	20c. Location - City or	Town, State
Ĕ	Peg in the sent of	4 □ Donation 5 □ Other (Specify)	Mo1	ntgomer		. 1	March 6,2004	Rethesda.	Maryland
saltimore,	permit. Peges. Depertment of the important: If its any injury or of once.	21. Signature of F Aral Service Licensee		22. N	ame and Addres	s of Facility Rol	ert A.	Pumphrey F	uneral Home/ onsin Avenue
מ	88 2 8	$\rightarrow (F - 2) F_{-1}$	M0033			Maryland			onsin Avenue
		23a. Part1. Enter the prease, or complications shock, or heart failure. His only one caus	that caused the death.	Do not enter t	he mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate
1	hysician	snock, or near failure.	e on each line.					1	Interval Between Onset and Death
	/Medical	Immediate Cause (Final disease or condition	Advanced Pel	luda Sa	rooma			 	6 Months
	Examiner	disease or condition resulting in death) a		is a conseque				1	o monens
-	<u> </u>								
1	incate be assouted physician and as the burial-transit edical Examiner	Sequentially list conditions,	Due to (or a	s a conseque	nce of):				
Š.	ba ax cian burial	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury test instructions of the cause.							
08/PD	physicial is the buri	that initiated events resulting in death) Last	Due to (or a	s e consequer	ice of):			1	
	= U W ==	d						j	
o n	at the death certified by the attending letached for use a Physician/M								
o i	the de ached hysic	Part II. Other significant conditions contributing	g to death but not resulti	ng in the unde	rlying cause give	en in Part I.	23b. Did to	obacco use contribute	to the cause of death?
7	w requires that the death center a signed by the attendin should be detached for usa interest by Physician/W	Advanced Chronic Obst	ructive Pul	Lmonary	Diseas	e	1 U Y	′es 2□No 3□Pi	obably 4 t Unknown
cords,	requires that een signed b hould be dete			<i>,</i>			24a. Was a	an autopsy 24b.	Were autopsy findings
	the law require tate has been so pege 2 should					-	perfor	med?	available prior to completion of cause
Ō.	nysician: The law has be director, pege 2 s				`		200000	2004	of death?
	r, pege	05 Wes					4D4		1 ☐ Yes 2 ☐ No
> :	this certific ral director,	25. Was case referred to medical examiner?			3 DOA Oth	26. Place of Death			
5	this raidi	ILI TES ZIANO	1 Inpatient 2 LEF	NOutpatient 8b. Time of	OLI DON	4 Li Nuising No		ence 6 X Other (Specow injury occurred	ify) Hospice
- I	h. After fune	1 Natural 5 ☐ Pending	(Month, Dey Year)	Injury	28c. Injun Work	(? Yes 2 □ No	2001 2000 1100 11	on mjary occarria	
noisinin	deat deat y tha	3 Suicide 6 Could not be	Place of Injury - At home	e. farm. street			28f. Location (S.	treet and Number or Ru	ıral Route Number.
3	tal or Attending Price at the Country of the Country of the Country of the Certification:	4 ☐ Homicide determined 256.	building, etc. (Specify)	-,,	,,		City or Town		
-		29a. Certifier 1 (X Certifying Physician:	To the best of my knowle	edge, death oc	curred at the tim	ne, date and place	and due to the c	ause(s) and manner as	stated.
	n 24 hou n 24 hou ne Funer pletely fil	(Check only 2 Medical Examiner: On	the basis of examination manner stated.	n and/or invest	tigation, in my of	pinion, death occurr	ed at the time, d	ate and place, and due	to the cause(s)
	within 2 to the comple	29b. Signature and tittle of certifier	0		29c. License	number	2	9d. Date signed (Month	n. Day, Yeer)
	2041	X 26/11/10			\cap	50412	218	7/15/2	
	w.	30. Name end address of person who completed	d cause of death (Item 2	3a) (Type, Prir		7 /	0	7 -10	
		Charles Harrison, M.D.	·			ad Rockvi	lle, Ma	ryland 2085	55
	State	31. Date filed (Month, Day, Yeer)	32. Registrar's Signatur	0 /	bouch				
	Registrar	MAR 1 7 2004	mena	he d	1/100 Mar				

			1 - For State Registrar	State of Maryland /	Departme Certifica	ent of Hea	alth and I	Mental Hygie	ene 200	4 10012
i	Physic /Medi		1. Decedent's Name (First, Middle, Last Alice R. Wohlfa	,				2. Date of Death Month March 16	Day Yeer	3. Time of Death $10:30P^{M}$
26	Examir		4a. Facility Name (If not institution, give Carriage Hill Nur	·		y, Town, or Lo	cation of Death	1	4c. County of De	eth
	Funeral Director		5. Social Security Number 6. Se		birthday) If Und	er 1 Year If	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y June 17,	Montgome 9. B 1915 Ma	ery Implece (State or Foreign Country) Ssachusetts
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If tem 27 is marked other than "natural", or flame 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examinar must be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County	a Drive 12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Dec If Yes, sp. 1 Yes 13. Decedent's Us (Give kind of wife. DO NOT Secreta 2b. Mailing Addre 2b. Mailing Addre 2b. Mailing Addre 2c. The control of Disposition (New, crematory of Come ry torium,	ip Code 20906 edent of Hispaneority Cuban, N 21 No S ual Occupation vork done durit use retired) 18. ss (Street and terlach ame of other place) Inc.	. Mother's Nam Eva No Number or Ru nen Dri Marc	pecify Yes or No- o Rican, etc.) king 16 king 16 17 18 18 18 18 18 18 18 18 18	Executive density or Town, State, c. Location - City o	ates erican Indian, ite, etc. nite s/Industry /e Zip Code) MD 20906 r Town, State Maryland
- 6	Physician /Medical Examiner portion and p	Ical Examiner	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	M00803 ications that caused the death. Do ne cause on each line. Hypertensive Due to (or as a consequence Cerebrovascu Due to (or as a consequence Cancer of Br Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence	e Heart e of): ular Acc e or): reast	ode of dying, so	uch as cardiac	se, Inc. 20814-3 or respiratory arrest,	7557 Wisc	Tuneral Home/ consin Avenue Approximate Interval Between Onset and Death
C. Box 6	I the death certific by the attending p ached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ② No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	th 3 Ectopic 5 Other (s				23d. Date of de Month	livery Day Year
ecords, P.	w requires that been signed t should be deta	by	Part II. Other significant conditions con	stributing to death but not resulting	in the underlying	cause given in	Part I.			o the cause of death?
r		Completed						24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
VII	ysician s certif director	o Be	25. Was case referred to medical examiner? 1 Yes No	lospital: 1 Inpatient 2 ER/O	Outpatient 3 🗆 🗅	0.1		h (Check only one) ome 5 Residence	6 DOther (Soc	oifu)
DIVISION OF	To the Hospitel or Attending Physician: within 42 hours after death . To the Funerel Director. Atter this certifica completely filled in by the funeral director, p.	Certification; T	27. Manner of Death 1 🛣 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b.	Time of Injury M	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how is		city)
Ž	oitel or Att urs after d rrel Direct		4 Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify)				28f. Location (Street City or Town, St	tate)	
	the Hosp in 24 hor the Fune ipletely fi	ledical	one)	sician: To the best of my knowledg ner: On the basis of examination ar and manner stated.	ge, death occurred nd/or investigation	d at the time, d n, in my opinio	late and place, in, death occur	and due to the cause red at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
ï		Σ	29b. Signature and title of certifier Morras	V. Posinh		D47330	mber		nate signed (Monter)	
٠			30. Name and address of person who co Thomas V. Joseph			on Driv	70 #200			land 20852
	Sta Registr	Sec	31. Date filed (Month, Day, Year) MAR 1 9 200	32. Registrar's Signature	4 1	a. 10 +	J, 1120	, ROCKVII	.re, mary	Tand 20072

State of Maryland / Department of Health and Mental Hygiene 1

10013

						Cert	ificate o	f Death		Reg. No.	04	100	13
		·		1. Decedent's Name (First, Middle, Last)					2. Date of I	Death		3. Time of D	eath
190		Physic /Medi		Gerard Joseph White					Month March	24, 200	Year 4	1:30	PN
	3	Exami		4a. Facility Name (If not institution, give street	and number)			4b. City, Town,	or Location of De		ty of Deeth	1 - 1 - 1	
				Homewood at Crumland	Farms			Frederic	k	Frede	rick		
		Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	**	If Under 1 Yea Months Day		in. 8. Date of E	Birth Day, Year)	9. Birthp	olace (State or F	-oreign
0		Director		111-18-1926	80				Jan.	2, 1924	New Y		
3		pu ဲ		Usual Residence of Decedent 10a. State 10b. County	100 Ci	y, Town or Loca	otion					I0d. Inside City	1.1
113		lanyiz	5	,			ation				,	1 ☐ Yes 2	
		289-1	ect	Maryland Frederick 10e. Street and Number	Fre	derick	101 71- 0-1-			40. 011 . 4			
-0'b: 1330		with	늅				10f. Zip Code			10g. Citizen of	What Coun	itry?	
	,	death with the Maryland ms 23a or 28a-f show r nast be notified at	Funeral Director	6220-A Glen Valley To	1	C 10.1W	21701	(I lianania Origina)	(Canalé : Van au h	USA		todion	
3	_	ter d	S	Ar	as Decedent Ever in U med Forces?	,5. 13. W	as Dacedent of Yes, specify Cu	f Hispanic Origin? ıban, Mexican, Pu	erto Rican, etc.)	No- 14. Ha	ice - Americ ack, White,		
	20	irs af	by	3 ☐ Widowed 4 ☐ Divorced Ye	XIYes 2□No Yes, Give 1943- par or Dates:	-46 1E	□Yes 2∏ N	o Specify:		Speci	fy:		
	21215-0020	2 hou		15. Decedent's Education	ar or battor.		nt's Usual Occ	upation		16b. Kind of E	Whi		
	75	nin 7	Completed	(Specify only highest grade comp		(Give kii life. DC	nd of work don O NOT use retii	upation e during most of v red)	vorking	TOD: TRING OF E	70311103371110	addity	
	212	yiene r tha	E	Elementary/Secondary (0-12) Co	llege (1-4or 5+)	Police				Law En	forcer	ment	
	P	e file I Hyg othe	Bec	17. Father's Name (First, Middle, Last)			011100	-	ame (First, Midd	le, Maiden Surna		HOHE	
-	lar	Ald by Alenta Al	ToE	John Francis White				Kathryn	Somervi	111e			
70	Maryland	shot and A man	Ι-	19a. Informant's Name/Relationship (Type, Pr.	int)	19b. Meiling	Addrass (Stre	et and Number or	Rurel Route Num	ber, City or Town	, State, Zip	Code) 217	01
7	Σ	alth alth 27 ls		Catherine Theresa Wh:	ite, wife			Valley T					
5	J.	othe othe		20a. Method of Disposition		Place of Disposit	tion (Name of		Date	20c. Location			
3	Ē	Page nent c nr: if		1 🕅 Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State	irview (,	3/29/200	4 Redbar	ak, Ne	ew Jers	ey
40/46/6: 00d	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "naturel, or Items 23a or 28a-f show eny Injury or other treumatic event, the Medical Examiner mast be multified at once.		21. Signature of Funeral Service Licensee		22. 1	Name and Add	ress of Facility K	1				-
700	m	Depariment Important	1 3	PRO M. Ba	MO(0999 106	6 East	Church S	troot F	lu basio. Trederici	z MD	21701	Oille
1		* 4*		23a. Part1. Enter the disease, or complication:	that caused the deat						C FID	Approximate	
4		Physician		shock, by heart failure. List only one cause	se on each line.			,	as or roop natory	4.1001	I I	Interval Betwee	en ath
		/Medical		Immediate Cause (Final	Park		' ,	reas-					
		Examiner		disease or condition resulting in death) a	1 GY C	1710	1 1)	14014	7			Xgars	
6)		Je.		Du o i eud	r as a conseque	ence or):				i		
4	7	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	Examiner	Sequentially list conditions	Due to (o	r as a conseque	ance of).			-111	J.		
9	۰,	an ar nial-t	ŭ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	- 30 10 (0								
White	68760,	te be ysicia ne bu	/Medical	Ceuse (Disease or injury that initiated events resulting in death) Last	Due to (or	r as a conseque	nce of):						
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2	P.O. Bo	dea ne att	Physician	Part II. Other aignificant conditions contributing	g to death but not resu	ulting in the unde	erlying cause g	iven in Part I.	23b. Dic	tobacco use co	ntribute to	the cause of d	leath?
5	P.0	at the by the	F						10	Yes 2 No	3 ☐ Prob	pably 4 □ Uni	known
76	Ś	res that the designed by the a	ρ						-		-	-	
3:	of Vital Records,	v require been si should I	Completed						24a. Wa	s an autopsy formed?	ava	ere autopsy findi ailable prior to	•
7	Ö	e law r has be ge 2 sh	p e								con	npletion of caus death?	\$ 0
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25	ita	ysicien: The scertificate director, pag	Be (25. Was case referred to medical examiner?				26. Place of D	eath (Check only	one)	1		
0	5	S S D	흔	1 Yes 2 No Hospital	i: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA O	ther: Jursing	Home 5 ☐ Res	sidence 6 □Oth	er (Specify	<i>'</i>)	
3	20	ding Ph h. After thi funeral		27. Manner of Death 28a. 1 Natural 5 ☐ Pending	Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ury at		how injury occur			
d	. <u>is</u>	Attending or death. ector: After by the fune	ă	2 Accident Investigation				Yes 2□No					
4	Division	l or Atta after de Directa d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e.	Place of Injury - At he building, etc. (Specify	me, farm, street	t, factory, office)		(Street and Numbown, State)	er or Rural	Route Number	;
X		Ital o	3						4				
Gnown tuphypicián As: Gerard		To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medicai	29a. Certifier (Check only 2 Medical Examiner: Or	To the best of my known the besis of examinat	wledge, death or ion and/or inves	ccurred at the t	ime, date and place	e, end due to the	cause(s) and ma	anner as sta	ated.	
S		the hin 2 the land	8	an	d manner stated.								
1		5 4 × 10		29b. Signature and title of certifier	1	r		ise number	5	29d. Date signe	1 :	Jay, Year)	
				/ lul	he wi		DO	1015	r	7/92	104		
-		5		30. Name and address of person who complete									
					200 Coppern		id, Woo	dsboro, l	Maryland	21798			
		Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signal	ure	10 . See	100					
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			_ For	State of Maryland /	/ Departm	ent of Healt	th and Me	ental Hygie	ne .	
			1 - State Registrar	•		ate of Dea			No. 2001	10014
	Physici	an	1. Decedent's Name (First, Middle, Las	" 1170110				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, give	Watts	45.0	ib. Tour and soul	tion of Booth	-EBRUARY	28 2004	J.43 A M
	Examir	ıer	GOOD SAMARIT	TAND HOSPITAL	40. 0	ity, Town, or Local	mol s		4c. County of Dea	ın
	Funeral		Social Security Number 6. Se	7. Age (In yrs. last	birthday) If Ur Mont		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, Ye	9. Bir	hplace (State or Foreign
	Director		UNK Usual Residence of Decedent	DM 201 79	Yrs.	no days mod	1	1ay-5, 1	924 N	·C·
	yland now		10a. State 10b. County	10c. City, To	own or Location					10d. Inside City Limits
	e Mar	ctor	MD Balti	more ?	Baltin	Jore				1 TYes 2 □ No
	with th	Funeral Director	10e. Street and Number	. D 1	10f.	Zip Code	17	10g.	Citizen of What Co	ountry?
	ns 23a must	erai	1011 Reverd	12. Was Decedent Ever in U.S.	13 Was De	cedent of Hispania	C Origin? (Spec	ofy Yes or No-	14. Race - Ame	HI.
0	after or priter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🗖 No	If Yes,	specify Cuban, Mex	xican, Puerto R	lican, etc.)	Black, Whit	
2	tited within 72 hours after death with the Maryland Hygiene. tither than "naturel", or Items 23a or 28a-f show tith. The Micklotal Exempliar must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 1 40	s 2.X No Spe	ecify:		Specify: \2	olack
2	in 72 r nat	Completed	15. Decedent's Edi (Specify only highest grad	de completed)	(Give kind of	Isual Occupation work done during Tuse retired)	most of workin	g 16t	. Kind of Business	Industry
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2	ould be filed with Mental Hygiene. arked other than atic event, treat	Be	17. Father's Name (First, Middle, Last)	11.		18. N	Aother's Name	(First, Middle, Mail	den Sumame)	
2	should be ind Mental marked of umatic eve	2	James Wo	11+5		u	UK_	2600000000		71717
2	C/ 10 - 10		19 Informant's Name/Relationship (T	Assisted human	ing Addi	es Street and Ni	umber or Hural	Houte Marber, Cl	or Town, State, 2	Zip Code) Z (Z 1Z
, מ	s f and of Health item 27 other tr		20a. Method of Disposition	- CO-	of Disposition (Name of or other place)	Da	ate 200	Location - City or	Town, State
all III	Pages ment of sant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ I • 4 ■ Donation 5 ☐ Other (Specify)	nemoval from State	ward I	Hed Sch	vool 2	128/04	Whsh.	DC
_ _ _	permit. Pages 1 au Department of Hea Important: If item any injury or otha once.		21. Signature of Funeral Service Licens	588	22. Name	and Address of F	acility		10	
	T. 7331		23a. Part1. Enter the disasse, or comp	lic trons that caused the death. D	o not enter the r	node of dvina, sucl	h as cardiac or	respiratory arrest		Approximate
	Physician	l li	Immediate Cause (Final	one cause on each line.	(-1 -	Tutar	re tion	,	1	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to or as a consequence	ce of):	7-01				
	Examiner	<u>.</u>	Sequentially list conditions,	b	Single Control					
	t insit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequenc	CO (II):					
ç,	ate be execu nysicien and he burial-tra	Examin	that initiated events resulting in death) Last	C. Due to (or as a consequence	ce of):					
9	tate be executed by sicien and the burial-transit	dicai		d						
2	certific Iding p	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy						
9	death a atten d for u	Iclan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	ath 3 □Ectopi	c pregnancy (specify)			23d. Date of del Month	overy Day Year
)	v requires thet the death certifics been signed by the attending pt should be detached for use as t	Physician/Med	9 Unknowл	9□ Unknown						
ָהָ הַ	ires th signed	þ	Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlyir	g cause given in P	Part I.			the cause of death?
Ś	w requir been si should	Completed						1 Tes		
5	The lay	dmo						24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
Ī	ding Physician: The law n. After this certificate has t funeral director, page 2 s	BeC	25. Was case referred to medical examiner?			26. P	Place of Death	1 ☐ Yes 2 💢 (Check only one)	No 1 Yes	2 □ No
> 5	hysic this ce al dire	၉	1 □ Yes 2 No			OOA Other: 4	☐ Nursing Hom	e 5 🗆 Residence	6 □Other (Spec	city)
5	ding Phys h. After this funeral di	Certification:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	o. Time of Injury	28c. Injury at Work? 1 ☐ Yes		3d. Describe how in	njury occurred	
2	Atten r deat ector: by the	Ifica	Z Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home,			_	3f. Location (Street	and Number or Ru	ral Route Number,
5	ital or rs afte ral Dir led in	Cert		building, etc. (Specify)				City or Town, S		
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one) Certifying Phy	sician: To the best of my knowled iner: On the basis of examination a and manner stated.	ige, death occur and/or investigat	ed at the time, data ion, in my opinion,	te and place, an death occurred	nd due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	Vithi To tl	ž	29b. Signature and title of certifier	218.5		29c. License numb			Date signed (Monti	
			· Columb	Houn		U 3	5875	6 MA	RCH 2, 2	2004
			30. Name and address of person who c	ompleted cause of death (Item 23a	a) (Type, Print)	5601	LOCH	KAVEN	BOULEV	IARD TO
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature		D TALL	respect	pentry	7770	4317
Ju L	Registr MH 17 Rev 1/2	-	MAR 3	1 2004 Areas	14 19	and .	•			
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Elia B. Young 2004 8:18 P /Medical March 15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 💢 F Days Hours 376-34-5017 Director 68 July 21,1935 Texas Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 XYes 2 No Be Completed by Funeral Director Crawford AR Van Buren 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1203 Cartwright Street 72956 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 K Married Maryland 21215-0036 1 XYes 2 □ No Specify: Mexican White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygies
Importent: If flem 27 is marked other ti
enty injury or other traumatic event, III
once. Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Homer Luna Lola Llanez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa A. Young/ Daughter 12476 Walnut Cove Circle, Germantown, MD 20874 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐Donation 5 ☐ Other (Specify) Fort Smith National Cemetery 22. Name and Address of Facility DeVol Funeral Home, 10 East 21. Signature of Funeral Service Vicents IRACI Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or comshock, or heart failure. List only or complications that caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, physician Completed by Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, should be Pancreatic Cancer with metastases to Liver and Spleen 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the funeral director, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 X No 1 Inpatient 2 X ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deat To the Funeral Director; 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2 cause of death (Item 20a) (Type, Print) 30. Name and address of person who complete William Dooley, M.D., 9901 Medical Center Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 17 Registrar

		1	For State Registrar	State of	f Marylan	d / Depa <i>Cei</i>	artment of H	lealth ai D <i>eath</i>	nd Mental Hyg	iene 2(004	10016
			Decedent's Name (First, Middle	e, Last)					2. Date of Dea	th	V	3. Time of Death
п	Physicia		Philip	James	Au	ıffartl	1		Month March 2	9. 2004	Yeer	6:10 p ^M
	/Medio Examin	-	4a. Fecility Name (If not institution				4b. City, Town, or	Location of		4c. County	of Death	
	2	•	31 Theo Lane				Towson	n		Ba1	timoı	re
	Funeral		5. Social Security Number		7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Birth Min. (Month, Day	Year)	9. Birthp	place (State or Foreign
	Director		212-22-7986	1 X M 2□F	77	Yrs.	Months Bays		Sept 10			land
	p ,		Usual Residence of Decedent		100 Cib	y, Town or Lo					1	Od. Inside City Limits
	show tel	-	10a. State 10b. County		Toc. City	y, rown or Lo	cation					1 ☐ Yes 2 🔣 No
	Ba-f	ct l		imore	3	Cowson						
	or 2	Directo	10e. Street and Number				10f. Zip Code			log. Citizen of		ntry?
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	within 72 hours after death with the Maryland ene. than "naturel", or Itama 23a or 28a-f show ta Masical Examiner mant be notified at	Funeral	11. Marital Status	Armed Fo	dent Ever in U. rces?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig in, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)		ck, White,	etc.
36	or I	by Fi	1 Never Married 2 Man 3 XWidowed 4 Divorced	If Yes, Giv	2 No		1 ☐ Yes 2 🕱 No	Specify:		Specif	γ: τ.	√hite
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D	Hygi Hygi Sther		17. Father's Name (First, Middle,		a	LA	e Covere		's Name (First, Middle,			.1011
Maryland	o da da	o Be	Rev. George	H. Auffar	th, Sr.			Alı	na	Waxmut	h	
<u></u>	should I nd Meni narke	2	19a. Informant's Name/Relations		, 52.	-	ng Address (Street		or Rural Route Numbe	r, City or Town,	State, Zip	Code)
<u>≅</u>	nd 2 sho lith and M 27 in me		Richard P. Auf	farth/Brot	her	1904	Pot Spri	no Ros	ad, Timoniu	m_ MD	21094	4
	s 1 and if Health itam 27 other tr		20a. Method of Disposition	rar cu, broc	20b. P	Place of Dispo	sition (Name of		Date	20c. Location		
5	ages ant of t: N i		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		State		natory`or other plac	1	11/04	Daltina	l	form! and
Baltimore,	artme ortan injur		21. Signature of Funeral Service	1-11-1	(2) day		Cemetery Name and Addres			вателно	re, r	Maryland
Ba	permit. Pages: Department of P important: If its any injury or of		Bryan W. C		exel		emmon Fu	neral	Home of Du Road, Timon	laney V	alley	Inc. nd 21093
			23a. Part 1. Enter the disease, o	r complications that c	aused the deat						Lylai	Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on	ach line.	11 02	n					Onset and Death
	Pnysician /Medical		disease or condition resulting in deal	a	(or as a conseq		<i>D</i>					- IYR
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Ć,	be executed ician and burial-transit	Еха	resulting in death) Last	Due to	(or as a conseq	uence of):						
8760,	ate be ex hysician the burial	ical		d								
89	5 0 5											-
Вох	eath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		come of pregna		35			23d. Da	te of deliv	ery
m	d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregr	oirth 2 Feta nant at time of d]Ectopic pregnancy] Other (s <i>pecify)</i>	<u> </u>		Me	onth	Day Year
0	that the dended by the a	hys	9 Unknown	9∐ Unkn	own							
S, P	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditi	ons contributing to d	eath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use con	tribute to t	he cause of death?
ğ	n sign								1 D Y	es 2XNo	3 Prot	oably 4 Dunknown
Record	w require been si	ompieted							24a. Was			opsy findings available
Be	The lay ate has page 2	E C							autop perfor	mad?	death?	mpletion of cause of 2 No
Vital		C	25. Was case referred to medica	ai l				26 Place	of Death (Check only o	2A No	1 🗆 100	2010
>	Physician: this certific ral director,	0 8	examiner? 1 ☐ Yes 2 No	Hospital	Inpatient 2	ER/Outpatie	nt 3 DOA Oth	00	sing Home 5 🔀 Resid		ner (Specii	fv)
of		F ii	27. Manner of Death	28a. Date		28b. Time o		y at	28d. Describe h			,,
Division	Attanding F r death. actor: After by the funer	atlo	1 Natural 5 Pendi 2 Accident invest	ng (Mon igation	iii, Day 1 eai)	Injury		Yes 2□N	lo			
<u>×</u>	i or Attandi after death. I Director: A d in by the fu	Hic	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 286. Place	of Injury - At h		reet, factory, office		28f. Location (S City or Tow	treet and Num	ber or Rura	al Route Number,
ā	al or afte	Certification:	4 Transido	Build	ing, etc. (Specif	77			0.0, 0. 70.	m, Diato)		
	pspit hour inere y fille								place, and due to the			
	To the Hospital or within 24 hours after To the Funerel Direction completely filled in b	edical	(Check only 2 Medica		asis of examina	anon and/or in	vestigation, in my o	pinion, deat	h occurred at the time, o	acte ariu piace,	and due t	o ine cause(s)
	To the To the comp	ž	29b. Signature and title of certific		1	1.	29c. Licens	e number	-, -,	29d. Date signe	d (Month,	Day, Year)
			1 Zawar	rl 1. (WV	w M	(L) (C)	175	03	March :	30, 2	004
,	DXI		30. Name and address of persor	who completed caus	se of death (Iter	п 23а) (Туре,	Print)	•				
_	10		Edward P. Cos					14, Ti	monium, MD	21093		
	Sta		31. Date filed (Month, Day, Year	la a	Registrar's Signa	atus	parker					
	Regist	rar	APR 0 1 20	U4 .	7	/	/					

PAILLE AUFFARTH

_			1 - For State Registrar	State of Mary	rland / Depa	artment of F	lealth ai		giene,	2004	10017
*	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last Hedwiga As. Facility Name (If not institution, give	Ida	Akela	itis 4b. City, Town, o	r Location of	2. Date of De Month March	30, Day	2004 Year County of Death	3. Time of Death 7:30 A M
	Funeral Director		Perring Parkway N 5. Social Security Number 216-12-2488 6. S		yrs. last birthday) 83 Yrs.	Parky If Under 1 Year Months Days	/ille If Under 24 Hours	8. Date of Bi Min. (Month, D. Feb. 3	45	ltimore 9. Birth Cou 1 Ma	County place (State or Foreign ryland
	ih the Maryland or 28a-f ehow	irector	Usual Residence of Decedent	ore Co.	c. City, Town or Lo	ville				en of What Cou	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
900	be filed within 72 hours after death with the Maryland that Hygiene. dother then "natural", or items 23a or 28a-f ehow event, I'm Medical Examination mail be notified at	d by Funeral Director	2900 Placid Ave 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	NUE 12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates:			21234 lispanic Origi an, Mexican, Specify:	n? (Specify Yes or No Puerto Rican, etc.)	o- 1	nited S 4. Race - Ameri Black, White, Specify:	can Indian,
Maryland 21215-0036	Hygi ther int,	e Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12) 12 yrs. 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired Clothing	g Buyer		De	d of Business/Ir partmen Gurname)	
arylan		To Be	Victor Burwic	:k	19b. Mailir	ng Address (Street		zanne or Rural Route Numb	Unkr		o Code)
Baltimore, M	pes 1 and of Health if Item 27 or other tr		Mr. Paul M. Janow 20a. Method of Disposition 1 Burial 2 Coremation 3 4 Donation 5 Other (Specific	Removal from State	20b. Place of Dispo cemetery, crer		ce)	Eugene, Date /03/2004	20c. Loc	ation - City or T	
Balt	Demit. Peg Department Important: eny injury once.		21. Signature of Funeral Service Licer	7/	L	eonard J	. Ruck		05 Ha	yland rford R	d.
5	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Due to (or as a co	oncero:	al In	forc		irrest,		Approximate Interval Between Onset and Death LO MIN
68760,	eath certificate be executed attending physicien and for use as the bunal-transit	ilcai Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co							
P.O. Box 6	the d	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1	Fetal death 3	Ectopic pregnancy Other (specify)	,		23	3d. Dale of deliv Month	ery Day Year
	w requires that been signed be should be det	by	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.		Yes 2		he cause of death?
Vital Records,	sician: The law certificate has b rector, page 2 st	e Completed							psy ormed? 2D No	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
o	ng Physicia Iter this certi neral directo	To B	25. Was case referred to medical examiner? 1 Yes 2 Namer of Seath 1 Namer of Seath	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time of		er: 450Nurs	of Death (Check only sing Home 5 28d. Describe	dence 6		(y)
Division	I or Attendii after death. Director: A I in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined		At home, farm, str Specify)		Yes 2□N	28f. Location (Street and wn, State)	Number or Rur	al Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	(Check only 2 Medical Exar	ysician: To the best of m niner: On the basis of exa and manner stated	amination and/or in	vestigation, in my o	pinion, death	place, and due to the occurred at the time,	date and p	place, and due t	o the cause(s)
	To t To t	M	29b. Signature and title of certifier		(1)	29c. Licens	e number	PC	29d. Date	signed (Month,	Day, Year)
	17 Sta	ite_	30. Name and address of portin who MICHAEL SUTE 31. Date filed (Month, Day, Year)	_	Signature	4000 Rd		BATTIMO	E	MO	21234
DH	Regist		APR 0 1 20	104 Benev	a B	Space	1				

		1 - For State Registrar	State of	of Maryla		partment d e <i>rtificate</i>	of Health and M of Death	Mental Hy	ygiene Reg. No.	7 11 11 W	10018
Dhysis	ion	1. Decedent's Name (First, Midd	ile, Last)					2. Date of D Month	eath Day	Year	3. Time of Death
Physic /Med			INSON					MARCH	29	2004	3:50 A ^M
Exami	ner	4a. Facility Name (If not institution	- Tr	ım bər)		,	wn, or Location of Death	1	4c.	County of Death	
	7	JOSEPH RICHEY 5. Social Security Number	6. Sex	7. Age (In y	rs. last birthda		TIMORE Year If Under 24 Hrs.	8. Date of B	irth	N/A	place (State or Foreign
Funeral Director		215-14-9081	1 □ M 2 💢 F	83	Ven	Months D	ays Hours Min.	8. Date of B (Month, D	ay, Year) 2-192		place (State or Foreign intry) MD
P		Usual Residence of Decedent									
anylar ehow	2	10a. State 10b. Count	у	10c.	City, Town or	Location					10d. Inside City Limits 11 Yes 2 □ No
he M	ecto	MD N	/A		BALTI	10RE 10f. Zip Co	ude.		10a Citi	zen of What Cou	
with be or	٥	3608 COTTAGE A	VENIIE			,	21215		rog. om	USA	
death	nera	11. Marital Status		edent Ever in	n U.S. 13		t of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or N	10-	14. Race - Amer	
1215-0036 within 72 hours after death with the Maryland ene. then "naturat; or Items 23e or 28a-f show ha Madical Examinat must be recitied at	Completed by Funeral Director	1 X Never Married 2 ☐ Ma	rried 1 Tes	2 X No ive		1 ☐ Yes 2 ☑		o nican, etc.)		Black, White Specify:	, etc.
0003	d b	3 Widowed 4 Divorce	d Year or [Dates:	160 Day	**			105 V	BL	ACK
15- in 72	jete	(Specify only high	nt's Education est grade completed,		(Gi	cedent's Usual O ve kind of work o . DO NOT use n	rccupation fone during most of worl etired)	king	16D. KI	nd of Business/Ir	ndustry
212 d within piene.	mo	Elementary/Secondary (0-12)	College ((1-4or 5+)		OMESTIC				HOME	
Ind 2121 be filed within tal Hygiene. d other then 's	BeC	17. Father's Name (First, Middle	, Last)				18. Mother's Nam	ne (First, Middle	e, Maiden	Sumame)	
Alaryland 2 should be to and Mental 1 e marked o	To E	ARTHUR ATKINSO	N				EMMA JA	NE HAW	KINS		
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28a-1 show other traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relation MILDRED SHIPLE				-	treet and Number or Ru .GE AVENUE			r Town, State, Zi MARYLANI	
Te, M	1 3	20a. Method of Disposition	1/NIEGE	208		position (Name or rematory or other		DALITIN		cation - City or T	
Baltimore, I permit. Pages 1 an Department of Heati Important: If Item 2 any injury or other		1 d Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State		rematory or other N CEMETE	1	5-2004			, MARYLAND
Baltimor permit. Pages Department of Important: If It any injury or once.		21. Signature of Funeral Service					ddress of Facility JAI				
		James	9.7	nort	ton		LAURENS S'			RE, MARY	
		23a. Part 1. Enter the disease, of shoot or heart failure. Lis	or complications that st only one cause on	caused the deach line.	leath. Do not e	inter the mode of	f dying, such as cardiac	or respiratory	arrest,	- X	Approximate Interval Between
Pnysician		Immediate Cause (Final disease or condition	a CO1	ranan	y arte	ry dise	euse				Months
/Medical		resulting in death)			equence of):	7					
) =Xaminer		Sequentially list conditions,	b. Due to	(or as a cons	sequence of).		-				
Dall Fill	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	~								
exection and and right transfer	Exa	resulting in death) Last	Due to	(or as a cons	sequence of);						
3 2 2 (See 28 26 26 26 26 26 26 26 26 26 26 26 26 26	edicai		d								
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Records, P.O. Box (The law requires that the death certif the has been signed by the attending bage 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?		utcome of pre birth 2 □ F mant at time o	etal death	B Ectopic pregr			2	3d. Date of delive Month	ery Day Year
P.O. that the ded by the detached	nysic	1 Yes 24 No 9 Unknown	9□ Unkr		or dealtr ,	Other (special	y)				
S, P.	by Pt	Part II. Other significant condi	tions contributing to	death but not	resulting in the	underlying caus	e given in Part I.	23e. Did	tobacco u	se contribute to t	the cause of death?
cords, vrequires	ed b	Dementia						1 🗆	Yes 2	No 3□Pro	bably 4 tonknown
FK{} ecord law requir as been s	Completed	Diabetes						24a. Wa	s an opsy	24b. Were auto	opsy findings available
(Con							perl	formed?	death? 1 ☐ Yes	ompletion of cause of 2 No
on of Vital ding Physicien: The Afferth's certificat funeral director, ps	Be	25. Was case referred to medic examiner?	Hospital:				26. Place of Dea Other:	100			115-115
Phys raidis	5	1 ☐ Yes 2 ☑ No 27. Manner of Death	14		2 ER/Outpat 28b. Time		4 Nursing H	ome 5 Res		Other (Speci	m Hospice
ZOR	tion	1 Natural 5 Pend	ling (Mor tigation	of Injury orth, Day Year	r) Injun	м	Injury at Work? 1 Yes 2 No				
Division Tor Attending after death. Director: After lin by the fune	Certification:	3 ☐ Suicide 6 ☐ Could	minad 208. Plac	e of Injury - A	At home, farm,	street, factory, of	ffice	28f. Location	(Street and	d Number or Run	al Route Number,
Div Div itel or A rrs after ral Direction by	Cer				444			<u></u>			
DIVI To the Hospitel or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical	29a. Certifier 1 Certify (Check only 2 Medica	il Examiner: On the l	basis of exam	knowledge, de nination and/or	ath occurred at t investigation, in	he time, date and place, my opinion, death occur	, and due to the rred at the time	a cause(s) , date and	and manner as s place, and due t	stated. o the cause(s)
othe mple	Med	29b. Signature and title of certif		nner stated.		29c. Li	icense number		29d. Date	e signed (Month,	Day, Year)
A F S F S		15-1801	DD				D24170		Mari	129.	2004
		30. Name and address of perso	n who completed cau	use of death	I em 23a) (Typ	e, Print)	10 1		1 1000	n - 1, 1	
10		E. TSOMO F	Lidney Hos	pice ?	38 N	Eutaw	St Balt	more	MD	2120	1
Si Regis	tate trar	31. Date filed (Month, Day, Yea	2004	egistrar's Si	gnature	Sport	2				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10019 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 10:35 AM Clarence Nelson Amrein March 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Manor Care Ruxton Towson Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours | Min. | 8. Date of Birth (Month, Day, Year) NOV. 26, 1 9. Birthplace (State or Foreign Country) Maryland 6. Sex 1 → M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Nov. 85 1918 218-01-8502 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mentle Ihyglene. Important: if them 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exampres must be institlined at any injury or other traumatic event, the Medical Exampres must be institlined at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Funeral Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2903 Chenoak Avenue 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 AYes 2 □ No If Yes, Give Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🛣 No Specify: Specify. Be Completed by white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Ferdinand Amrein May Fannie Wisnom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 9604 A Amberleigh Lane; Perry Hall, MD 21123 on (Name of Date 20c. Location - City or Town, State Barbara Beres daughter Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 4/2/04 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lin-nsee 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in each line. Approximate Interval Between Onset and Death 23a. Part1. En er the disease, or complications shock, or heart failure. List only one caus Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Fueral Director: After this certificate has been signed by the ettending physician end completely filled in by the Innertal finestor, page 2 should be dateched for use as the buriet-trensit Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yea 2 ☐ No ģ 24b. Were autopsy findings 24a. Was an autopsy performed? Be Completed available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 20 No 4 A ursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Alatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 d Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 1 2004

32. Registrar's Signature

			1 - For State Registrar	State of Ma	ryland	l / Depa <i>Cer</i>	rtmer tificat	nt of Hotel	ealth and Death		Reg.	ne 20	0 L;	100	20
	Physici	an	Decedent's Name (First, Middle, Last	•						2. Date of Month			'ear	3. Time of De	
	/Medic		William Henr		chous	e, Sr.				March	_28,			3:20 I	P ^M
	Examin	er	4a. Facility Name (If not institution, give 118 Fairmont Dr.					l Air	Location of De	ain		4c. County of	beath ford		
	Eupoval		5. Social Security Number 6. Sec		(In yrs. la	st birthday)	If Unde	r 1 Year	If Under 24 H		Birth	9	Birthpl	ace (State or Fo	oreign
	Funeral Director			M 2□F	73	Yrs.	Months	Days	Hours M	in. (Month, Dec.	Day, Yo	ear)	Count Count	ry)	
	P .		Usual Residence of Decedent												
	arylan show	-	10a. State 10b. County		10c. City,	Town or Loc	cation						10	od. Inside City L 1 ∐ Yes 2]	
	8a-f	Director	Maryland Harford		_Bel	. Air	1				1				A1140
	with ti	들	10e. Street and Number 118 Fairmont Drive				10f. Zij	L014				. Citizen of Wh	at Count	iry?	
	ns 23	erai	11. Marital Status	12. Was Decedent E	ver in U.S	. 13. V			spanic Origin?	(Specify Yes or		USA 14. Race -	America	n Indian.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fulury or other traumatic event. The Medical Examinar must be notified at once.	by Funeral	1 ☐ Never Married 2 Married	Armed Forces?	0	l lt	Yes, spe	city Cubar	Specify:	erto Rican, etc.		Black,	White, e	etc.	
215-0036	hours tural'	d be	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	1951-	16a. Deced	ont'e Heu	al Occupa	tion		161	b. Kind of Busi	Whit		
15	in 72 na " na	Completed	(Specify only highest gra	de completed)	,	(Give I	kind of wo	ork done di ise retired)	uring most of v	working	101	b. Kind of Busi	i lessy ii lu	ustry	
212	y with	E	Elementary/Secondary (0-12)	College (1-4or 5+	•)	Meat	: Cut	ter				Grocer	v St	ore	
	e filed al Hygi l other vent.	BeC	17. Father's Name (First, Middle, Last)						18. Mother's N	lam <i>e (First, Mi</i> o	die, Mai				
Maryland	should be find Mental 8 marked of	To	Arthur John	Burkhous	se			.	Anna	Hele	na	Sp	role	2	
Nar	2 sho		19a. Informant's Name/Relationship (7			19b. Mailin	g Address	s (Street a	nd Number or	Rural Route Nu	mber, C	ity or Town, St	ate, Zip (Code)	
	1 and Health am 27 ther to		Ethel M. Burkhouse	e - Wife	20b Pla	118 I	aim	me of	Drive.	Bel Air	, M	aryland	210	14	_
יסר	Pages nent of h int: If ite		1 X Burial 2 ☐ Cremation 3 ☐		cer	metery, crem	atory or o	other place	· 1				,		
Baltimore,	it. Partmer		' 4 □ Donation 5 □ Other (Specify 21. Signation of Futeral Service Licen		вет	Air N				01/04 McComas	-	el Air,			
Ba	permit. Departr Imports any inji		Stephe Offee	ds		50) W.	Broad	dway St	reet, E	el A	Air, Ma			14
	/Medical Examiner	Examiner	23a. Part 1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	one cause on each line a	conseque	ellu ence of):	lov			Cinon				Interval Betwee Onset and Dea	ath H
68760,	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or as a	conseque	ence of):									
.O. Box	ath certif ttending or use a:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	2 🗌 Fetal o	déath 3 🗌	Ectopic p Other (sp	regnancy oecify)			_	23d. Date of Month		y Day Yea:	ır
٩	ires that the designed by the a	þ	Part II. Other significant conditions of	ontributing to death but	t not result	ting in the un	derlying o	cause give	n in Part I.		id tobac □ Yes	,	ute to the	e cause of death	
Sor	w require been si should b	ete								24a. W	· ·		ro autom	ou findings ava	ulablo
Records,	siclan: The law certificate has b irector, page 2 s	Completed								- ai	utopsy erformed	#2 ∣ dea	ith?	sy findings ava- pletion of caus	e of
Vital	an: T tificat tor, pa	Be C	25. Was case referred to medical						26. Place of E	1 ☐ Ye Death (Check on		No IL	Yes 2	No No	
Ž	Physiclan: r this certific ral director,	To B	examiner? 1 ☐ Yes 25 No	Hospital: 1 ☐ Inpatien	nt 2□E	R/Outpatient	3 D	Othe		Home 5 €R		e 6 □Other	(Specily)		
on of	ding Physician: The h. After this certificate h. funeral director, page	Certification:	27. Manner of Death 1 Avatural 5 Pending	28a. Date of Injury (Month, Day	Year) 2	28b. Time of Injury	M	28c. Injury Work	at ? ′es 2 □ No	28d. Descri	be how	injury occurred			
Division	Attending r death. sctor: After y the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injur	ry - At hom	ne, farm, stre				28f. Locatio	n (Stree	t and Number	or Rural	Route Number,	;
Ö	el or safter	Serti	4 Homicide	building, etc.	. (Specify)					City or	Town, S	itate)			
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exen	ysicien: To the best of niner: On the basis of and manner stat	examination	ledge, death on and/or inv	occurred	at the time	e, date and pla inion, death oc	ace, and due to to	he caus ne, date	e(s) and mann and place, and	er as sta d due to t	ted. the cause(s)	
	To the within To the complex	Me	29b. Signature and title of certifier				29	c. License	number		29d.	Date signed (M onth, D	ay, Year)	
	. 2 0		Da at	when w	0		1	041	0118		M	arch	20	th 21	104
. h	11		30. Name and address of person who	completed cause of de	ath (Item 2	23a) (Type, F	Print)	·/	~ (0	2 0	1	i	(^		-
11	Sta		JANET COD	PER MI) r's Signatu	141	rt	70	OVK F	Kel L	-u1	rervil	le_	MD 2	1093
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State of Maryland / Department of Health and Mental Hygiene 2001 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10:45 PM MARCH ARLENE 26,2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL Date of Birth (Month, Day, Year) (D) 1) 21, 1964 MEMORIAL NION 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Hours Days 1 □ M 2 KF Months 7-47-1329 NERTH CAROLINA Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State items 23a or 28e-f show the Medical Examiner must be notified at 1. Yes 2 □ No BALTIHORE Directo MARYLAND 10g. Citizen of What Country? 10e. Street and Number 80 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 5 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 Specify. BLACK ۵ 3 Widowed 4 Divorced natural Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) then. Flementary/Secondary (0-12) College (1-4or 5+) SALON EAUTICIAN other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sh ment of Health and lent: If Itam 27 is m jury or other traum 100 3 AVENUE, WEST Columbia SC 29169 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State permit. Page Department of Importent: If eny injury or once. VCEMETERY 04-06-04 COLUMBIAS. * 4 ☐ Donation 5 ☐ Other (Specify) and Address of Ficility BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Livensee 22. Nam N. FULTON AVE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ariest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition METASTATIC YEARS **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. East of conditions (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. the attending physician by Physician/Medicai IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Month Year ō 5 Other (specify) 1 ☐ Yes 2 ☑ No PO detached 9☐ Unknown 9 Unknown ģ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 ₽No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Hnpatient ě Certification; To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After I Nespitel or Attending 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and bue of certifie 29c. License number MARCH 26, 2004 amouna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOIDITAL, 201 E. UNIV. PKNY DUTHUMANA JOHEPH MD 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

עט			1 - State of Maryland / Dep	artment of Health and ertificate of Death	Mental Hyg	giene 2004	10022
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month MARCH	ıth	3. Time of Death
	/Medi		BENSON E BROWN JR.	1 4 Ci Tu and a Ci 4 Day		25, 2004	6:35P. M
	Examir	ıer	4a. Facility Name (If not institution, give street and number) 328 N.FULTON AVE	4b. City, Town, or Location of Dea BALTIMORE	un	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 10 M 2 F 7. Age (In yrs. last birthday Yrs.) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birth	place (State or Foreign intry)
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Maryl -f ehc	tor	MO NA BALTIMO	RE			1 XYes 2 No
	or 28s	Oirec	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou	ntry?
	• 23e	erai [328 N. FULTON AVENUE	Was Danadast of Hispania Deigin 2 /	Consider Van de No	USA 14. Race - Ameri	ean Indian
9	toges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event, the Medical Examinar must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 11. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes, Give	Was Decedent of Hispanic Drigin? (Sif Yes, specify Cuban, Mexican, Puer 1 Yes 2 💆 No Specify:	to Rican, etc.)	Black, White,	, etc.
003	hours 'ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				CK
21215-0036	nin 72 n "nat	plete	(Specify only highest grade completed) (Giv	edent's Usual Decupation e kind of work done during most of we DO NOT use retired)	orking	16b. Kind of Business/Ir	dustry
212	filed with Hygiene other tha	Completed	12TH GRADE NIA (CHEF		HOSPITALI	ГУ
Maryland	2 should be filed withir and Mental Hygiene. ie marked other than aumatic event, Ira M	Be	17. Father's Name (First, Middle, Last) BENSON BROWN , SR	18. Mother's Na	rme (First, Middle,	Maiden Sumame)	
aryl	should and Men marke	2		ing Address (Street and Number or R	Tural Route Number	r. City or Town, State, Zij	Code)
	1 and 2 Health a om 27 le			AMBLING DAKS		HONGHILLE	MO 21228
Baltimore,	permit. Pages 1 and Department of Health Importent: If Item 27 eny injury or other tr 2005e.		1 Burial 2 Locremation 3 Hemoval from State	ematory or other place)	Date	20c. Location - City or T	
Itin	permit. Pag Department Importent: I eny injury o		'4 □Donation 5 □Other (Specify) 21. Signature of Fun (Fal)Service Licensee	2 Name and Address of Facility		BALTO . M.)
Ba	Departr Importe eny inju		Dansk C	REMATION SERVICES	s KE, BALT	0. MO 212	29
Yan Xan	Tale be executed whereign and hysician and hysician and hysician and the burial-transit	I Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one causing each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, farry leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	whi (edwa	rule	Villase	Onset and Death
P.O. Box 68760	death certifid e attending p id for use as	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	□Ectopic pregnancy □ Other (specify)		23d. Date of deliving Month	Day Year
	e ig	by	Part II. Other significant conditions contributing to death but not resulting in the to	inderlying cause given in Part I.	23e. Did toi	bacco use contribute to t es 2 KNo 3 ☐ Prot	he cause of death?
Vital Records,	The ate h page	Completed			24a. Was a autops perform	sy prior to co med? deatb?	opsy findings available impletion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:		ath (Check only on		SCENE
of	Attending Physic death. • ctor: After this by the funeral did	tion: To	1 Yes 2 No	THE SELECTION APPROXIMENT		ence 6 AOther (Specifical Specifical Specifi	y) SCEAL
Division	afte Dir	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (St City or Town	treet and Number or Rura n, State)	tl Route Number,
	To the Hospital or within 24 hours after To the Funeral Dircompletely lilled in I	edical (29a. Certifier (Check only bank) Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place execution, in my opinion, death occurred.	e, and due to the curred at the time, d	ause(s) and manner as s ate and place, and due to	tated. o the cause(s)
	vithin To the comple	Me	29b. Signature and tille of certifier	29c. License number	2	9d. Date signed (Month,	Day, Year)
	•		(& (o shew))	O.C.M.E.	M	IARCH 26,200	4
	7		30. Name an address of person who completed cause of leath (Item 23a) (Type		Pal+ima-	no Masseland	21201
4	Sta	ete.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	111 Penn Street,	ватслиот	.e, Marylano	. 21201
	Regist		APR 0 1 2004 Magas	M. Brook s			

State of Maryland / Department of Health and Mental Hygiene 2 1 1 10023 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 3:30 P^M Marion Μ. Becker March 30. 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 529 Parksley Avenue Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea APR 3, 19 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ⊡ M 2 💢 F 214-18-7736 83 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or Items 23a or 28e-1 show traumatic event, Ite Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No N/A Baltimore Director Maryland 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel, or Items 23a or 2 ery injury or other traumatic event, In Mudical Exemptation once. 21223 **USA** 529 Parksley Avenue Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Factory 6 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be UNK. UNK. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Geraldine Olsen/Daughter 4 Doe Court Phoenix, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

`4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 4-1-04 Baltimore, MD 21. Signature of Funeral Service Licencee

Thomas Gregor 22. Name and Address of Facility Cremation Society of MD, 299 Frederick Road Bal Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) attending physician Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 2 No 25. Was case referred to medical 28. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation efter death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 🗌 Homicide filled in I 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hos within 24 ho To the Fun completely f (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DU055018 March 31, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan D. Darer, MD 10 Hopkins Plaza Baltimore, MD 21201 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State APR 0 1 2004 outs Registrar

	1	For State Registrar	State of Mary			t of Health e of Deatl			iene _{sg. No.} 200	4 10024
Physicia	n	1. Decedent's Name (First, Middle, La	Barber				2	2. Date of Deat Month Yarch	Day Yes	
/Medica Examine Funeral	er 4		is Hospita	yrs. last birthday,	-	Town, or Location Town, or Location	ove	B. Date of Birth	4c. County of D	eath A Birthplace (State or Foreign Country) MD
Director wow		Usual Residence of Decedent 10a. State 10b. County		c. City, Town or L		nore		10 12	19112	10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
with the	Direc	10e. Street and Number 921 N. Payso	n Street		10f. Zij	2121	7	1	0g. Citizen of What	
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I within 72 liene. r then "na tre Medic	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5+)	(Giv.	edent's Usu e kind of we DO NOT L	. 1		g	Dental	oss/Industry Office
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The law ate has b page 2 s	e Comple	25. Was case referred to medical	T 5:2			26. PI	ace of Death	24a. Was autop perfor 1 Yes	sy prio med2 dea 2 No 1 □	re autopsy findings availabler to completion of cause of the three cause of the cau
Phys	To B	examiner? 1 Yes 2 No 27. Manner Death 1 Natural 5 Pending	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpati	of	OOA Other: 4 28c. Injury at Work?	Nursing Hon	ne 5 🗆 Resid	lence 6 Other ((Specify)
To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be Ose Place of Injury	- At home, farm, Specify)	M street, facto	1 ☐ Yes 2		28f. Location (S City or Tox		or Rural Route Number,
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To the within 2 To the comple	Me	29b. Signature and title of certifier	+ C.S.	L (Hom 222) /T	-	9c. License numb			199d. Date signed (Month, Day, Year)
∫ St	ate	30. Name and address of person w Laamont (31. Date filed (Month, Day, Year)		000 W.		imore	Stree	t Bal	timore	MD 21223

DHMH 17 Rev 1/2001

		• •	Department of Health and Mental Hyg	
		Registrar		eg. No.
Physic /Medi		1. Decedent's Name (First, Middle, Last) Macy Brown	2. Date of Death Month MARCH	Day, Year 1159 M
Exami		4a. Facility Name (If not institution, give street and number) St, Agnes Health care	4b. City, Town, or Location of Death Baltmore	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 191-62-7130	rithday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, Yrs. July 7, 76	9. Birthplace (State or Foreign Country)
yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow		10d. Inside City Limits
the Ma 28a-f e	ecto	My N/A Ball 10e. Street and Number	101. Zip Code 10	1 ☐ Yes 2 ☐ No Og. Citizen of What Country?
ath with 23a or	rai Di	ZZY N. Payson St.	2123	0810
lore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hyglene. If Item 27 is marked other than "natural", or Items 23a or 28s-f show or other traumatic event, the Medical Examinate statistic at a context and the modified at	Completed by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036 d within 72 hours af gjene. er than "natural", or	npieted	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
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and 2 sl and 2 sl salth and n 27 te r		Callene Sye Iniece	224 N. Payson St. Bulton	cre up sizzs
ages 1 and of He It: If Iten		cemete	of Disposition (Name of / ery, crematory or other place) - Zvon Cen. 4/5/04	20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Importent: If Item any Injury or othe once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hami P. Cose Funenal S 109 Tessier St. Bulto	ewice, P.A.
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executed executed burial-transit	i Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence consequence)	9 of):	
D 20	ledicai	d.		
Records, P.O. Box 68 The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery Month Day Year
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	on:	27. Mann of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b.	Injury Work?	ow injury occurred
Division or Attending after death. Director: After	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No farm, street, factory, office 28f. Location (St	reet and Number or Rural Route Number,
Div Hospitel or 24 hours after Funerel Dire				
Division To the Hospitel or Attent within 24 hours after deati To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge of the control of the control one one of the certifying Physician: To the best of my knowledge of the certifying Physician: To the best of my knowledge of the certifying Physician: To the best of my knowledge of the certifying Physician: To the best of my knowledge of the certifying Physician: To the best of my knowledge of the certifier of the	ge, death occurred at the time, date and place, and due to the ca and/or investigation, in my opinion, death occurred at the time, da	ate and place, and due to the cause(s)
To the within 2 To the complete	Σ	29b. Signature and title of certifier Recurrent ATA		9d. Date signed (Month, Day, Year) March 30, 2004
7		30 Name and address of person who completed cause of death (Item 23a)	Caton Avenue Bultmare	March 30, 2004 e, Maryland 21229
· S Regis	tate trar	31. Date filed (Month, Day, Year) APR 0 1 200	. S. Sperki	l .

Physic	ian	1 - For Amend Item #26, Registrar 1. Decedent's Name (First, Middle, Last) VIOLA BLOW	per Dr verbal,	(830, <i>Cl</i>	1/2004 rtificate	872	eath	2	2. Date of De Month	eath Day	y Yea	3. Ti	me of Death
/Med Exami	ner	4a. Facility Name (If not institution, give s JOHNS HOPKINS BAY 5. Social Security Number 6. Sex	VIEW	s. last birthday)		IMOE	Location of	f Death	MARCH		County of D	eeth	0:04A ^
Funeral Director			M 2 X F 81		Months		Hours	Min.	3. Date of Bi (Month, Di 10-11-	-1922	9.1		tate or Foreig
the Maryland 28e-f show	ector	MD BALTIM 10e. Street and Number		DUNDALE		Pada				10a Cit	izen of What	1.7	ide City Limit:]Yes 2 ☐ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event. It is Marical Executive Living by Delifical and Once.	Completed by Funeral Director	134 CARVER ROAD		16a. Dece		1222 ent of His fy Cuban No	Specify:			0-	USA 14. Race - A Bleck, W Specify:	merican India thite, etc.	an,
nd 2 should be filed wi hith and Mental Hygien 27 is marked other th r traumatic svent, Ita	To Be Con	12 17. Father's Name (First, Middle, Last) WILLIAM CLINTON		NUF	RSE'S			,	First, Middle	e, Maiden	HOSPIT Surname)	ral	
and 2 sho ealth and I m 27 is me		19a. Informant's Name/Relationship (Type REV. SAMUEL BLOW/S	NO	8110	RIDG	ETOW		BA	LTIMOR	RE, M		236	
permit. Pages 1 ar Department of Hea Important: If Item any injury or othe once.		20a. Method of Disposition Structural 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	emoval from State	Place of Dispo cemetery, crea OLLY H1	matory or oth	M. G	RD.	Dat 4-3-2 JAMES	2004	MI	DDLE F	RIVER,	MD
Physician /Medical Examiner physician and physician and the price transit	ical Examiner	23a. Park. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):	V	0	ANC		respiratory a	arrest,			ximate at Between and Death
res that the death certifica igned by the attending pr be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tat death 3	Ectopic pre					2	23d. Date of o	delivery Day	Year
w requires that the de been signed by the should be detached	b	Part II. Other significant conditions conditions	ributing to death but not re	esulting in the u	nderlying ca	ıse given	in Part I.			tobacco u Yes 2[se contribute		of death?
The law requires the cate has been signed, page 2 should be c	Completed	`									prior t death	autopsy find o completion ? es 2 \(\text{No}	of cause of
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient X 28a. Date of tnjury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		Other: c. Injury a Work?	4 □ Nurs	sing Home	Check only of 5 Resid. Describe	idence 6	S □Other (S) y occurred	pecify)	
spital or Attend ours after death veral Director: , filled in by the f		4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)			data and		City or To	wn, State)			Number,
To the Hospital within 24 hours a To the Funeral t completely filled	Medical	29b. Signature and title of certifier	cian: 10 the best of my kr ar: On the basis of examir and manner stated.	nation and/or in	vestigation, i	the time n my opin License r	nion, death	piace, and	at the time,	date and	and manner place, and designed (Mo	ue to the cau	
10	ate	30. Name and address of person who con ICUS North Pa. 31. Date filed (Month, Day, Year)	npleted cause of death (tte Royal 32. Registrar's Sign	Ba	Print)	Such	te no	24 2173) 4				

State of Maryland / Department of Health and Mental Hygiene 2001

				Certi	ficate of Death	1	Reg. No.
	Di dida		Decedent's Name (First, Middle, Last)	D		2. Dete of Dee	_
	Physiciai /Medica		Thomas	5	ARNES	MARG	h 28 2004 7.7M
	Examine		4a Fecility Neme (If not institution, give street end number)			or Location of Death	
			3515 DUNHAVEN ROAD		DUNDA		BALTIMORE
	Funeral Director		219-50-1432 XM 2□ F 55	13. Idal Dilliody		Hrs. 8. Date of Birt Min. (Month, Da)	
	and and	+	Usuel Residence of Decedent 10a. Stete 10b. County 10c.	City, Town or Local	tion		10d. Inside City Limits
	Mary	ō	MD BALTIMORE	DUNDAL	K		1X Yes 2 □ No
	r 28a	<u>8</u>	10e. Street end Number	DUNDAL	10f. Zip Code		10g. Citizen of What Country?
	h with		3515 DUNHAVEN ROAD		21222		USA
	deat	je l	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U,S. 13. Wa	s Decedent of Hispanic Origin es, specify Cuban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0020	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Madical Examiner must be routled at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates V ☐ T	1□	Yes 2 No Specify:		Specify: BLACK
5-0	72 h	etec	 Decedent's Education (Specify only highest grede completed) 	(Give kin	nt's Usuel Occupation and of work done during most of	working	16b. Kind of Business/Industry
121	within the	Ē	Elementary/Secondary (0-12) College (1-4or 5+)		NOT use retired)		BETHLEHEM STEEL
d 2	filed v Hygie other t	ပ္မွ	17. Fether's Name (First, Middle, Last)	SUPE	RVISOR 18. Mother's	Name (First, Middle,	
an	ould be filed with Mental Hygiene. arked other than atic event, the	To Be	JOHN THOMAS BARNES		EMM	A MCARTHU	R
Maryland	2 should and Men le market	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing			er, City or Town, State, Zip Code)
	and 2:	- 1	WANDA BARNES/WIFE	3515	DUNHAVEN ROAD	BALTIMO	RE, MARYLAND 21222
Baltimore,	ges 1 and t of Health if Item 27 or other tr	ŀ	Zoa. Motified of Dioposition	D. Place of Dispositi	ion (Name of tory or other place)	Date	20c. Location - City or Town, State
Ë	Pages nent of I int: If Ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ARBUTUS M	EMORIAL PARK	4-2-04	BALTIMORE, MARYLAND
a	permit. Pag Department Important: i any injury o	-	21. Signature of Funeral Service Licensee	22. N	lame and Address of Facility J		ORTON & SONS F.H., INC.
Ω	20 E E 8		James 9 Mos	ton 17	01-31 LAURENS	ST. BALT	IMORE, MARYLAND 21217
	Physician /Medical Examiner		23a. Part1 Inter the disease, or complications that caused the disease or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death)		the mode of dying, such as car I Failure once of): Pulmonary		Onset and Death
	\$p.	ē	Chronic	Op Yuch	once of): Delmanar	V Disease	e- Find Stage
Box 68760,	ntificate be ng physicia a as the bu	n/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a conseque	ence of):		
œ.	death e atte	<u> </u>	Part II. Other significant conditions contributing to deeth but not	resulting in the und-	erlying cause given in Part I.	23b. Did 1	tobacco use contribute to the cause of death?
P.O.	v requires that the death cer been signed by the attendin should be detached for use	Completed by Physician/				132	Yes 2□ No 3□ Probably 4□ Unknown
S,	es the	ò	Renal Failure Diabeles Mellitus		18.00	-	
ord	een s hould	S S	Diabeles Mellins			24a. Was perfo	an autopsy 24b. Were autopsy findings available prior to completion of cause
Sec.	e law has b	du					of death?
al F	cate h	ខ្ល				101	
V.	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Other:	Death (Check only o	
on of	ling Phys	ion: To	27. Manner of Deeth 1 Matural 5 Pending (Month, Dey Year		28c. Injury et Work? M 1 Yes 2 No	-	dence 6 □Other (Specify) how injury occurred
Division of Vital Records,	or Attending after death. Director: After I in by the fune	ertifica	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - A building, etc. (Spe	it home, farm, stree ecify)		28f. Location (S City or Tov	Street and Number or Rural Route Number, vn, State)
	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai Certification:	29a. Certifier (Check only one) 1	knowledge, death of investion and/or inves	ccurred at the time, date end p stigation, in my opinion, death o	lace, and due to the occurred at the time,	cause(s) and manner as steted. date and place, and due to the cause(s)
	Vithin Fo the	Š	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Yeer)
			Gillie A ann MP		058959		March 31,2004
· ·	1		30. Name end address of person who completed cause of death (I	item 23e) (Type, Pr	int)	1	March 31,2004 timura, MD 21201
27		-,-,	Jolene Brown MP		ION GREENES	treet BAL	timura, MJ 2120/
	State Registra	- 62	31. Date filed (Month, Day, Year) 32. Registrer's Si	Sature Spor	KS		

DHMH 16 Rev 6/95

X19-50-1438

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 10028 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** March 28, 2004 2:15 P M Evelyn Josephine Breig /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ruxton Baltimore Manor Care | If Under 1 Year | Il Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 21,1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 218-18-4930 87 Pennsvlvania Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Funeral Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 805 Elderbank Court 21286 <u>U.S.A.</u> death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed House Keeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be es 1 and 2 should be fi of Health and Mental H I itam 27 is marked otl r other traumatic svar 2 Ludwia Ch1udnv Josephina Martus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Joan Jeffries Daughter 805 Elderbank Court Towson, Maryland 21286 20b. Place of Disposition (Name of Disposition of Disposition (Name of Dulaney Valley Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ξ ö permit. Page Department i Important: If any injury or 3-31-2004 Timonium Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached for 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an certificate has b irector, page 2 s autonsy performed? 1 ☐ Yes 20 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 은 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attending Natural 5 Pending death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerei I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of serion who completed cause of death (Item 23a) (Type, Print) MARCH 31, 2004 DOO 60560

Registrar DHMH 17 Rev 1/2001

State

PANIGAT

31. Date filed (Month, Day, Year)

2004

APR 01

ORIGINAL

201-109 32. Registrar's Signature

BACK RIVER MECIL

RD

BALTIMORE, MA

KHETERPAL

				For State Registrar	1 10000	State o	of Marylar	nd / Depa	artmen rtificate	t of H	lealth a	and M	ental Hy	giene	2004	10029
		8.30	4	1. Decedent's Name (F.	First, Middle, La	ıst)							2. Date of De	ath Day	Year	3. Time of Death
		Physici /Medic		Elza Col	le Cha	ppell			,				March :		004	02:22 A ^M
		Examin		4a. Facility Name (If no	_						Location of	of Death			County of Death	1
			A. S.	Upper Chesa					Bel If Under		If Under	24 Hrs	0 Data - 4 Bi		arford	
		Funeral		5. Social Security Numb		Sex 1□M & F	7. Age (In yrs. 98	Yrs.	Months	Days	Hours	Min.	8. Date of Big (Month, Da Apr. 1	ay, Year)		nplace (State or Foreign untry)
	-0	Director		224-24-98 Usual Residence of De									Thr.T	,1703	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ginia
		ylanc how		10a. State 10	0b. County		10c. Ci	ity, Town or Lo	ocation							10d. Inside City Limits
		the Marylan 28e-f show notitied at	ctor	Maryland	Harford	d		Forest	Hill							1. Yes 2. No
		or 28	Director	10e. Street and Numbe					10f. Zip						en of What Co	untry?
R		s 23a	rai	2416 Minn	ilck Dri		edent Ever in U	10 12		1050	Issania Ori	ain? (So	oify Ves or N	USZ	4. Race - Amer	ican Indian
22		ter de Item	Funerai	11. Marital Status 1 Never Married	2 Married	Armed Fo	orces?	7.5.	If Yes, spec	ify Cuba	in, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)		Black, White	
6	936	urs af	by	3⊠ Widowed 4 □	_	If Yes, Gir Year or D	ve		1 Yes	2 √ 2 No	Specify:				Specify: Wh	ite
0	5-0036	d within 72 hours after death with the Maryland jiene. r than "neturel", or items 23a or 28e-f show ir than "neturel", or items 23a or 28e-f show the Medical Exercitival termidified at	Completed		5. Decedent's E	ducation ade completed)		16a. Dece	dent's Usua kind of wo	I Occupa	ation	t of worki	na	16b. Kin	d of Business/I	ndustry
	21	ithin 7.	npie	Elementary/Seconda		College (life.	DO NOT us	e retired	1)					
	121	T1 75 5 10	S	17. Father's Name (Firs	est Middle I ac	1		Sc	hoo1	Teac		ar'e Name	(First, Middle			ucation
	Maryland 2121	ntal H ed ot	Be	· ·			-210						ancis M			
_	2	should be find Mental Is marked of umatic eve	2	Layfayett			lare	19b. Maili	na Address	(Street a					Town, State, Z	ip Code)
0	\mathbf{z}	O. 62		Roy L. Ch					•						yland	
13110	ē,	s 1 and 2 if Health item 27 l		20a. Method of Disposi	ition		20b.	Place of Disponent	osition (Nan	ne of ther plac	(e)	C	ate	20c. Loc	ation - City or 1	Town, State
	altimore,	Pages nent of I ent: If it		1 ☐ Burial 2 □ C 1 □ Donation 5 □			State Be.	l Air N	/lemori	al (Grdn I	Apr.	3,2004	Bel 1	Air, Ma	ryland
3	alti	permit. Pages 1 Department of H Importent: If ite any injury or ot		21. Signature & Funer	arService Lice	nsee	.)	2	2. Name an	d Addres	ss of Facility	HO	na			
	8	88258		Thank	esu	· hng	1	113	317 CC	kest	ו עיוור	Rd7	Abinado	on, Ma	aryland	, 21009
	Ю			23a. Part1. Enter the c shock, or heart fa	disease, or con ailure. List only	nplications that one cause on e	aused the dea each line.	th. Do not en	ter the mod	e of dyin	g, such as	cardiac c	or respiratory a	irrest,		Approximate Interval Between Onset and Death
		Pnysician		Immediate Cause (Findisease or condition	al	_ a	Aspir	atio.	7 /	100	Im o	neal	<u> </u>			24 hours
		/Medical Examiner		resulting in death)	-	Due to	(or a a conse	quence of):								
37		T A	-	Sequentially list condit	tions,	b. Due to	(or as a conse	guence of):								
50	0	nted Insit	min	Sequentially list condit if any, leading to imme cause. Enter Underlyin Dause (Disease or inju-	ng 4		(0. 20 2 0 0 0 0 0	, , , , , , , , , , , , , , , , , , , ,								
3	Ć,	te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last		c. Due to	(or as a conse	quence of):								
<u>u</u> 3	760	<u>~</u> ~ ~ •	cal			d										
H	68	eath certificat attending phy I for use as the	Medi	IF FEMALE:												
15	Box	ith ce ttendi or use	an/	23b. Was decedent pro in the past 12 mo		1 ☐Live I	itcome of pregr birth 2 ☐ Fet	al death 3 [⊒Ectopic pr		,			2:	3d. Date of deli Month	very Day Year
		ne dea the a	/sici	1 ☐ Yes 2 ☐ M 9 ☐ Unknown		4∐Pregi 9∐ Unkn	nant at time of a nown	death 5[Other (sp	ecrfy)						
	P.0	that the di ed by the detached	Phy	Part II. Other significat	int conditions	contributing to d	death but not re	suiting in the u	underlying c	ause give	en in Part I		23e. Did	tobacco us	e contribute to	the cause of death?
	ds,	signe signed d be	d by	Coron	Mry .	Actory	y Dis	ease	, ,				10	Yes 2	No 3 Pro	obably 4 Unknown
	Sor	w requir been si should	ete			s Dis							24a. Was	an	24b. Were au	topsy findings available
د۔	Vital Records,	Physician: The law requires that the death certifical this certificate has been signed by the attending phyral director, page 2 should be detached for use as the	Completed by Physician/Medi		1,24	<u> </u>	Civi	ε					auto	ormed?	death?	ompletion of cause of
20	ta	ician: The l certificate harector, page	a	25. Was case referred	l to medical						26. Place	of Death	1 Yes		1 193	20 140
U	-	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 ☑ No		Hospital:	Inpatient 2] ER/Outpatie	nt 3 DC	A Oth	er: 4 □ Nu	ırsing Ho	me 5 Res	dence 6	Other (Spec	rify)
-	n of	ding Ph h. After th funeral	:uo	27. Manner of Death	5 Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury	of 2	8c. Injury Worl	y at k?		28d. Describe	how injury	occurred	
ਹ	Sio	Attending r death. ector: After by the funer	cati	2 Accident	investigation	he -			M		Yes 2 🗌					
90	- ≥	after d Direct Direct	Certification:	4 Homicide	determined	4 286. Place	e of Injury - At t ling, etc. (Spec	nome, farm, st ify)	reet, factory	r, office			28f. Location (City or To	Street and wn, State)	Number or Ru	ral Route Number,
3	7	urs urs erel		29a. Certifier 1	D Cartifying D	hysician: To the	e best of my kn	owiedne deal	th occurred	at the tim	ne, date an	nd place	and due to the	cause/s) s	and manner as	stated
2	Division	To the Hospitel within 24 hours a To the Funerel I completely filled	edicai			miner: On the b										
		To the To the sompl	Me	29b. Signature and title	e of certifier	2/			290		e number				signed (Month	- '
		/			4/	K-	MD.			D	350	12		Mar	ch 31	2004
		K		30. Name and address	of rson who	completed cau	se of death (Ite	m 23a) (Type	, Print)	A	0	0	0/0	_	nd	2/014
		J		J. Kev	n LY	VCA N		Z /VO	Pan	100	,	00	-170	1	,	
		Sta Regist	ate rar	30. Name and address J. Ke V. 31. Date filed (Month,	0 1 200	14 /2	agistra agr	The state of the s	Mon	Seal.						

		-	1 - State of Registrar	Maryland / Dep <i>Ce</i>	ertificate of L		ental Hygier Reg. P		10030
	Physicia	27	Decedent's Name (First, Middle, Last)	0-2	wford			ay Yeer	3. Time of Death
	/Medic		Barbara			Location of Death		3 2004 lc. County of Death	0045 M
£.,	Examin	er	4a. Fecility Name (If not institution, give street and numb Johns Hopkins Bayview i	nedical Cente		Litimore		NIA	
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday			I. Date of Birth (Month, Day, Yea	9. Birthp	lace (State or Foreign
	Director		241-64-9565 ^{1□ M 2} ♥F	63 Yrs.	Months Days	Floors	ebruary 15	,1941 NC.	
	pu 🛊		Usuel Residence of Decedent 10a, State 10b, County	10c. City, Town or I	Location			1:	0d. Inside City Limits
	/aryla	٥	MD. Baltimore	Dundalk					1 ☐ Yes 2 X No
	28a-	rect	10e. Street and Number		10f. Zip Code		10g. (Citizen of What Coun	try?
	hours after death with the Maryland turet; or items 23s or 28s-f show at Exart, or must be notified at	Funeral Director	2712 Yorkway Apt D		21222			USA	
	death	ner	11. Marital Status 12. Was Deced Armed Ford	ent Ever in U.S. 13	. Was Decedent of Hi	spanic Origin? (Speci n, Mexican, Puerto Ri	ify Yes or No- can, etc.)	14. Race - Americ Black, White,	
ð	or its	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give	T	1 ☐ Yes 2 ☐XNo	Specify:		Specify: Whit	te
Š	hours tures	q pa	3 ☐ Widowed 4 ☐ Divorced Year or Dat 15. Decedent's Education		edent's Usual Occupa	ation	16b.	Kind of Business/Inc	
	filed within 72 Hygiene. Ither than "nal snt, the Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	(Giv	re kind of work done o DO NOT use retired,	<i>furing</i> most of working			
212	filed with Hygiene. other ther	Com	12 years	Swin	g Manager			Donalds	
Maryland 21215-0036	should be filed within 72 hours after death with the Marylan of Mental Hygiene. The marked other than 'natural', or flems 23s or 28s-f show marked other than 'natural', or flems 23s or 28s-f show marked other than 'natural'.	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (Elizabeth			
<u>Ya</u>	should be and Mental I amarked o	⁶	Charlie Bell	405.14-	iling Address (Street a				Code
Mar	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print) Dawn Bystry Daughter—Ir.		rawberry C				C00 0)
ص ص	s 1 and 2 should I Health and Mer Item 27 is marks other traumatic		20a. Method of Disposition		position (Name of rematory or other place	Da	te 20c	Location - City or To	wn, State
on o	ages ant of it: if it		1 ☐ Burial 2 X Cremation 3 ☐ Removal from Si `4 ☐ Donation 5 ☐ Other (Specify)	ate	Crematory or other place	e) April 2004	•	timore Ci	tv.MD
Baltimore,	permit. Pages 1 and Department of Healt Important: if item 2 any injury or other QDCE.		21. Signature of Funeral Service Licenses						
m	P = I		Chithony C. Con	nelly	22. Name and Addres Connelly F 7110 Solle	ers Point	Road, Dur	dalk,Md.	21222
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Of not e	enter the mode of dying	g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician	9 1	Immediate Cause (Final disease or condition	erdiore	girater	y arr	-621		Onsorand Double
B	/Medical Examiner		resulting in death) Due to	r as a consequence of):	n	10.00	lung	encer	
	S - - -	2	Sequentially list conditions, if any leading to immediate	r as a consequence of):	ruar-s mol	1 ag.	J		
	uted J Insit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events c.						
o Î	exectan and rial-tra	Еха		r as a consequence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d						
9	entifica ling pla e as t		IF FEMALE:	ama of prognancy				004 0-11-44-5	
Вох	eath certific attending p	by Physician/Me	23b. Was decedent pregnant 1 Live bir		3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	Day Year
o.	that the de ed by the a detached	ysic	1 Yes 2 No 9 Unknown		Ollier (Specify)				
٥.	res that the igned by be detact	y Ph	Part II. Other significant conditions contributing to dea	ath but not resulting in the	underlying cause give	en in Part I.	23e. Did tobaco	o use contribute to the	ne cause of death?
rds	w requires been sign should be	ed b					1 XYYes	2 □ No 3 □ Prob	ably 4 Unknown
000	aw requast been 2 should	Completed					24a. Was an autopsy	24b. Were auto	psy findings available impletion of cause of
ž	The late happened	Com					performed 1 ☐ Yes 2 🔀	? death?	
/ita	cian: ertific ector,	Be (25. Was case referred to medical examiner?		0#	26. Place of Death	(Check only one)		
5	Physician: r this certific ral director,	1 To	1 ☐ Yes 2 🕱 No Hospital: 1 ☐ In 27. Manger of Death 28a. Date o	patient 2 ER/Outpat		4 Nursing Hom	e 5 🗆 Residence 3d. Describe how in	6 ☐Other (Specification)	y)
UO	ding l h. After funer	tion	1 Natural 5 □ Pending (Month	, Day Year) Injury	y Worl	k? Yes 2 □No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division of Vital Records,	Attendir death.	fica	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm,	street, factory, office	28	Bf. Location (Street City or Town, St	and Number or Rura	I Route Number,
á	s after al Direct	Certification;	4 Homicide Buildin	g, etc. (Specify)		<u>U</u>	Only or Young, or	a10)	
7	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the ba and mann	sis of examination and/or	ath occurred at the tin investigation, in my o	ne, date and place, ar pinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	vithin somple	Me	29b. Signature and title of certifier		29c. Licens	e number	29d.	Date signed (Month,	Day, Year)
)	->		> beent c	mee	P	32808		5/31/0	Y
	10		30. Name and address of person who completed cause	of death (Item 23a) (Typ	oe, Print)	line en la seco	THE STATE OF THE S	1 4444	e1270.911
	ĮV.		Joseph A Curresse, 11	D 4940	Cusien A	WILL, O	Limbere	1110 211	22.4
1	Sta Regist	ate	31. Date filed (Month, Day, Year) 32. Re	sistrar's Signature	1 Loon	// -			

O		1 - For RegistrarAMEND TIEM #5 F	State of Maryland	/ Dena	artmen	t of He	alth and		giene 2	_	1003
Physici	an	1. Decedent's Name (First, Middle, Last		June	incate	- 01 D	Call	2. Date of Do Month	Day	Year	3. Time of Death
/Medic Examir		4a. Facility Name (If not institution, give	street and number)			Town, or L	ocation of Deal	MARCH		2004 unty of Death	7:12P. " /A
Funeral Director		5. Special Security Number 6. Security Number 10	7. Age (In yrs. last	t birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min	. (Month, D	rth ay, Year) F 1926	Cou	place (State or Foreign intry) SC
ING 21215-0036 be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or items 23e or 28e-f show avant. I'm Mulical Experiment outs by revitted at	Funeral Director	10a. State 10b. County MD N/A 10e. Street and Number +003 Oak-Ford 11. Marital Status 1 Never Married 2 Married	10c. City, TBA Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 You It yes, Give	LTII	UDR 10f. Zip	Code 2 ent of His	panic Origin? (5, Mexican, Puer	Specify Yes or N to Rican, etc.)	0- 14.	of What Cou US Race - Ameri Black, White,	ican Indian,
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene. 77 is marked other than "natural", or traumatic avant. I'te Medical Expri	Be Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	Year or Dates: Ideation 1 Secompleted) 1 College (1-4or 5+)	6a. Dece (Give life.	dent's Usua	Il Occupat k done du e retired)	ion irring most of wo	me (First, Middle	16b. Kind o	of Business/Ir	
Baltimore, Marylar permit. Peges 1 and 2 should be Department of Health and Menta Importent: If Itsm 27 is marked any injury or other traumatic avonce.	To	19a. Informant's Name/Relationship (7) LOUIS F. CACS A 20a. Method of Disposition 1 Method of Disposition 1 Method of Disposition 1 Denial 2 Cremation 3 Life 1 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenters	Removal from State 20b. Plac	HDO: e of Dispo etery, crei	3 Universition (Nameratory or of AWN)	ne of their place,	d Aver	ural Route Numb Me Date	20c. Locati	on - City or To	own, State
Physician /Medical Examiner physician and physician and physician and physician and physician and physician and physician physician	Ical Examiner	23a. Part1. Entèr Me disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, I saving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		tic C		, ,			arrest,		Approximate Interval Between Onset and Death
Records, P.O. Box 6876 The law requires that the death certificate to the has been signed by the attending physic age 2 should be detached for use as the box.	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of deatl	ath 3	Ectopic production of the control of				23d.	Date of delive Month	rery Day Year
Cords, P.O. I w requires that the de been signed by the a should be detached f	ted by Ph	Part II. Other significant conditions co	ntributing to death but not resultir	ng in the u	nderlying c	ause giver	n in Part I.		Yes 2 N	o 3 ☐ Prot	<u> </u>
of Vital Records, Physician: The law requires the this certificate has been signer rail director, page 2 should be d	Be Comple	25. Was case referred to medical					26. Place of De	24a. Was auto performed 1 Yes	psy ormed? 20 No	4b. Were auto prior to co death? 1 Yes	opsy findings available ompletion of cause of
or Attending Physitie death. Director Atter this in by the funeral di	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	Assital: 1 Inpatient 2 ER 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home building, etc. (Specify)	lb. Time o Injury	M 2	A Other 8c. Injury : Work? 1 \(\) Ye	4 Nursing I	Home 5 ☐ Res 28d. Describe	idence 6 X how injury oc	curred	ny) SCENE
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical Ce	25a. Certifier (Check only one). 29b. Signature and title of certifier	ner: On the best of my knowle ner: On the basis of examination and manner stated.	idge, death and/or in	vestigation,	in my opi	nion, death occ	a, and due to the urred at the time,	date and pla	ce, and due to	o the cause(s)
17		30. Name and address of person who con J.LARON LOCKE MD.	ompleted cause of death (Item 23	3a) (Type,	Print)	o.c.i		Baltimo	MARCH ore, M a		
Sta Regist	rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature 0 1 2004		is p	bart	(d)				

			For State	State of Marylar	nd / Departme	ent of Health and ate of Death			10032			
	ħ		Registrar 1. Decedent's Name (First, Middle, La.	st)	2. Date of							
	Physici /Media		BETTY	CHIN	7 .		Marth 3	30 04	1:30 A M			
Examiner			4a. Facility Name (If not institution, give	tallstown		ty, Town, or Location of De Randalled der 1 Year If Under 24 F	tom,	4c. County of Deeth	more			
	Funeral Director	4	210_10_0x	ex M 20 F 7. Age (In yrs.	Yrs. Month		Irs. 8. Date of Birth Month, Day,	Year) 4 Coul	place (State or Foreign intry) OH			
	hours after death with the Maryland tural', or Itema 23a or 28a-f e how al Exeminer must be notilised at	ior	Usuef Residence of Decedent 10a. State 10b. County Por H	10c. Ci	ty, Town or Location	lalistaum			10d. Inside City Limits 1 ☐ Yes 2 No			
	with the a or 28a Les notifi	Director	10e. Street and Number	idoe Deivo	10f.	Zip Code	10	g. Citizen of What Cou	ntry?			
	er death Itema 23 ner mus	Funeral	11. Maritaf Status	12. Was Decedent Ever in U	J.S. 13. Was De If Yes, s	cedent of Hispanic Origin? pecify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White,				
0036	hours aft ural', or al Exemp	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 Tes	Y -(Specify: B	ACK			
Baltimore, Maryland 21215-0036	be filed within 72 ital Hygiene. of other than "nale event, the Widele	To Be Completed	15. Decedent's El (Specify only highest gra		16a. Decedent's U (Give kind of life. DO NO	work done during most of t	working	6b. Kind of Business/In	LIC,			
			17. Father's Name (First, Middle, Last, LCV) John Son	1	1191	18. Mother's N	Name (First, Middle, M	aiden Sumame)				
	s 1 and 2 should f Health and Men itam 27 ie marke other treumatic		19a. Informant's Name/Relationship (ard (Dghte)	8810 FC	ess (Street and Number or	DR, Rar	dalbtown	n, mo 2113			
	0 0 = =		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 2)	Removal from State	Place of Disposition (formatory) HIMORE N	Name of or other place) OHOM 4	Date 2	oc. Location - City or To Baltimore	Stete			
Balt	permit. Pag Department Importent: I eny injury o	1	21. Signature of Funeral Service Licer		22. Name 	and Address of Facility V Liberty Ro	od Rand	reene Fur allotown	rerol Service MD 2112			
	Physician Physician		23a. Part1. Enter the discase, or com shock, or heart failure. List only fmmediate Cause (Final disease or condition	plications that caused the deal one cause on each line.	th. Do not enter the m	node of dying, such as card	liac or respiratory arres	st,	Approximate Interval Between Onset and Death			
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):								
	t I Insit	Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):		\$ V					
ds, P.O. Box 68760,	ate be executed ohysicien and the burial-transit	Completed by Physician/Medical Exa	resulting in death) Last	Due to (or as a consec								
	death certific e attending p id for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fett 4 Pregnant at time of c	23d. Date of delive Month	ery Day Year						
	es th; igned be de		Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlyin	g cause given in Part I.	pacco use contribute to the cause of death?					
of Vital Record	Hospital or Attending Physicien: The law 4 hours after death. Funeral Director: After this certificate has beily filled in by the funeral director, page 2 s						autopsy prior to completion of cause of death?					
ta		0	25. Was case referred to medicaf			26. Place of I	1 ☐ Yes 21 Death (Check only one	No 1 ☐ Yes	2 No			
Į.		To B	examiner?	Hospitaf: 1 ☐ Inpatient 2 ☐	nce 6 Other (Specif	(y)						
			27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28d. Describe how	cribe how injury occurred					
Division		Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, street, fact fy)	28f. Location (Stre City or Town,	f. Location (Street and Number or Rural Route Number, City or Town, State)					
		edical C		Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	1 //		29c. License number	296	d. Date signed (Month,	Pay, Year)			
•	(0		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	CUUSIA	SAN	S/31/	us,			
	Ψ	ata.	31. Date filed (Month, Day, Year)	32. Registrar's Sign	(VLEE	ND SI	1172 30	DO PILES	VILLE 21208			
	Sta Regist		ADD 0 -	. D	10 1							

DHMH 17 Rev 1/2001

	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 10033								
Physician /Medical	1. Decedent's Name (First, Middle, Last) Carolyn Lee Cross 2. Date of Death Month Day Year 1.0374								
Examiner	4b. City, Town, or Location of Death Ac. County of Death N/A 5. Social Socurity Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Months Days Hours Min. (Month, Dey, Year)								
Director -f show fired at tor	21/-62-3/6/								
	Maryland N/A Baltimore MXYes $2 \square No$ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3453 Keswick Road 21211 USA								
0036 hours after death with the turel; or Itams 23e or 28a al Everties must be red! et dy by Funeral Direc	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes ♀ ♀ □ No 11 □ Yes ♀ ♀ □ No Specify: Specify: White								
- 72 - 15- 15- 15- 15- 15- 15- 15- 15- 15- 1	The content of the co								
nd 21. nd 21. be filed w tal Hygier d other th event, the	12+ N/A N/A 17. Father's Name (First, Middle, Last) William C. Cross, Sr. Marion Dulin								
Cal Maryla 1 and 2 should Health and Men Traumatic To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Cross, Jr. Brother 36 Pleasant Drive Berwick, Maine 03901 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State)								
Baltimore, Baltimore, Department of Heal Important: If item 2 any injury or other once.	MXBurial 2 Cremation 3 Removal from State **A Donation 5 Other (Specify) **The state of the st								
O S S S S S S S S S S S S S S S S S S S	Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 23a. Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death								
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Severe Cardiomyopathy Due to (or as a consequence of): Multiprocian Failing								
760, le be executed ysicien and e burial-transit cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
Box 687 sath certificate authending phy: for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 1 No 9 Unknown 9 Unknown 9 Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year								
cords, P.O. requires that the de been signed by the should be detached	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Anknown								
Division of Vital Records, tor Attending Physician: The law requires that deter death. Director: Atten this certificate has been signed in by the funeral director, page 2 should be certification; To Be Completed by	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No								
of Vital Invision: The hysician: The his certificate of director, page To Be Co	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
Division of tall of Attending Physics after death. The discount of the funeral o									
Divisio To the Hospital or Attendividuo 24 hours after death To the Funeral Director: A completely filled in by the funeral Completely filled in Completely filled in the funeral Director.	28e. Place of Injury - At home, farm, street, factory, office determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
the Hosp thin 24 hou the Fune mpletely fil	(Chack only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
A September 1	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 30 04								
5	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
State Registrar	31. Date filed (Month, Day, Year) APR 0 1 2004 32. Registrar's Signature Apparature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Month Year **Physician** March 26, Bradley Lee Carpenter 18:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Laure1 Laurel Regional Hospital Prince George If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral №** M 2 | F 62 219-36-9816 July Maryland Director Usual Residence of Decedent death with the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 X Yes 2 ☐ No Director MD Prince George Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 918 Philip Powers Drive 20707 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural" or item 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify. Specify: Ā 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Firefighter BWI Airport 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Lee Carpenter Gladys Kliby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Carpenter/ Wife 918 Philip Powers Drive, Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or otl 1

Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 3/30/04 * 4 Donation 5 Dother (Specify) Brentwood, Maryland 22. Name and Address of Facility Fleck Funeral Home, Inc. 21. Signature of Funeral Service Licensee M01338 ema Towart 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ruptured Pulmonary Artery Minutes resulting in death) /Medical Due to (or as a consequence of): Examiner Brochogenic Carcinopa Due to (or as a consequence of): Months 5-coue tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physicien and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performed. 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2X ER/Outpatient 3 DOA 1 ☐ Yes _ 2 X No After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 13916 1) March 27, 2004 cause of death (Item 23a) (Type, Print) 321 Prince George Street, Laurel, Maryland 20707 William A. Warren, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's-Signature State APR 0 1 2004 Registrar DHMH 17 Rev 1/2001

			1 - For Amend Item Registrar	n #17 ;	State of l per th (:830	Marylar 4/1970	nd / Depa 74 tas Cer	artment of H tificate of	Health <i>Deatl</i>	and Menta h	al Hygie	ene 200	4 10035	
1. Decedent's Name (First, Middle, Last)								····		2. Da	te of Death	Day Yea	3. Time of Death	
	Physici /Medic		Doro	th	4 C	OPA	age	-			ch 30	, 2004	5:00 a M	
	Examin		4a. Facility Name (If not ins		e street and numb	er)	7	4b. City, Town, o		n of Death		4c. County of De		
			Gilchris 5. Social Security Number		Sex 7.	Age (In vrs	last birthday)	Towson If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9, Birtholace (State				DIE Sirthplace (State or Foreign		
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	anytar show	_	10a. State 10b. C	,			ity, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2√☐ No	
	28a-f	Director	Md. 10e. Street and Number	Balti	more	Pa	rkville	10f. Zip Code			100	. Citizen of What		
	with I	급	9007 Briar) Ood				21 23	3/.			US/	·	
	ms 23	Funeral	11. Marital Status	(Uau	12. Was Decede		J.S. 13. \	Was Decedent of H	Hispanic C	Origin? (Specify Ye	es or No-	14. Race - Ar	merican Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Evaluation to collised at once.	by	1 ☐ Never Married 2 ☐ 3 € Widowed 4 ☐ Div		Armed Force 1 Yes 2 If Yes, Give Year or Date	ZN0	1	1 ☐ Yes 2 ☑ No		an, Puerto Rican, y:	etc.)	Specify:	White	
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an	ould be Mental I arked o	To Be			d Goodli		Suring		E	thel Ma	y Fis	shpaugh		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Ms		19a. Informant's Name/Re	ationship	(Type, Print)		19b. Mailir	ng Address (Street	t and Num	ber or Rural Route	e Number, (City or Town, State	o, Zip Code)	
	1 and 2 Health a am 27 Is		Sandra K.	Call	anan/ Dau			D Erie Av	ve.	Baltimor				
ore	of He of He itam		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crem	ation 3 [☐Removal from Sta	1	Place of Dispo cemetery, cren	sition (Name of matory or other pla	ice)	Date	20	c. Location - City	or Town, State	
Baltimore,	Department of I Department of I Important: If it any injury or o		° 4 ☐ Donation 5 ☐ Ø	ner (Speci	(y) 2			e Cemeter	-	4-3-04		Uhite Hal	Ll, Md.	
Bal	permit. Departr Imports any inje		21. Signature of Funers Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204											
62,	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between											
			Immediate Cause (Final disease or condition resulting in death) Onset and Death 4 8 hours											
7			Due to (or as a consequence of):											
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ó,	cate be executed physician and the burial-transit	Exa	resulting in death) Last	- 1	Due to (or	as a conse	quence of):							
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Box 6	e law requires that the death certifi has been signed by the attending je 2 should be detached for use as	Completed by Physiclan/Med								23d. Date of delivery				
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Ö			urinary	red	ention		ity pa	ertension	∽	24	la. Was an autopsy	24b. Were	autopsy findings available to completion of cause of	
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Vital	ician: Th certificate rector, pag	Be	25. Was case referred to resummer?	edical				10		ce of Death (Chec	ck only one)	-		
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OU C	ng fter ne	ilon:		Pending nvestigation		Day Year)	28b. Time of Injury	Wo	ork?]Yes 2[escribe now	injury occurred		
Division	Attending r death. actor: After	fica	3 Suicide 6	Could not	be 28e. Place of	f Injury - At I	nome, farm, str	reet, factory, office		28f. Lo			Rural Route Number,	
á	al or safter	Certification:	4 🗌 Homicide		building	, etc. (Spec	nity) marazinas			Ci	ty or Town,	State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier 1 C C (Check only one)	ertifying P edical Exa	hysician: To the b miner: On the bas and manne	is of examin	lowledge, deat lation and/or in	h occurred at the ti vestigation, in my	ime, date opinion, d	and place, and du eath occurred at th	e to the cau ne time, date	se(s) and manner a and place, and d	as stated. lue to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of	certifier	1200	15		29c. Licen	ise numbe	r	290	Date signed (Mo	onth, Day, Year)	
•) wat	~ h) V V V	Cov			17	213-1		1 level	30,2004	
	10		30. Name and address of	erson who	completed cause	of death (Ite	em 23a) (Type,	Print) 6301 ^	J.ce	rerles.	54	Baltom	are 2/2/2	
	Sta Regist	ate rar	31. Date filed (Month, Day APR 0 1		32. Rec	gistrar's Sign	nature	park						

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DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) APR 0 1 2004 DHMH 17 Rev 1/2001

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

APR 0 1 2004

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registral MEND ITEM #5 PER FH G830 4/27/04 JHCertificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** CORBETT ISAAC /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE Specialty Hosportal iniversity If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 2-22-1916 Birthplace (State or Foreign Country)
 CC 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) **Funeral** SC 0971 88 30 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show the Medical Examinar must be notified at 1√ Yes 2 No Director BALTIMORE N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2401 ST. STEPHENS COURT #2B 21216 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 5 1 ☐ Yes 2 No Specify: Specify: 2 BLACK 3 Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) RESTAURANT COOK permit. Pages 1 and 2 should be filed v. Department of Health and Mental Hygies Important: if Itam 27 is marked other it any injury or other traumatic event, Ital 2006. 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARY ANN POWELL THOMAS CORBETT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) #2B BALTIMORE, MD 21216 2401 ST. STEPHENS CT. MARY ANN SANDERS/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 3-31-2004 METRO CREMATORY BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee 21217 1701-31 LAURENS ST. BALTIMORE, MD ames 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ila 1 month Physician /Medical Due to (or as a consequence of): **Examiner** mont eumone Sequential v list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit MUYE Due to (or as a consequence of) 68760, Completed by Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 ☐ Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? 2/2 No 1 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No ဥ this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 1 Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide illed in by 4 Homicide within 24 hours after To the Funeral Dire 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier tarit nich

Registrar DHMH 17 Rev 1/2001

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State

31. Date filed (Month, Day, Year)

APR 0 1 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 33. Registrar's Signature

ORIGINAL

601, South cha

		1 - For State Registrar	State of Ma		d / Depa		of Hea	alth an		Hygier	ne20	04	100	
Physici /Medic	al	1. Decedent's Name (First, Middle, Last) Paul B. Ciotta				4h Chi Ta		antina of F	Marc	of Death	Day 2004 4c. County o	Yeer	3. Time of De 5:20	
Examin Funeral	er	4e. Facility Name (If not institution, give Greater Baltimore 5. Social Security Number 6. Sei	Medical 7. Ag		r ast birthday)	4b. City, To TOWS If Under 1 Months E	son Year	Under 24		of Birth	Balt	imor	e ace (State or F	Foreign
Director		220-14-2459 Usual Residence of Decedent 10a. State 10b. County	X M 2□F {	10c. City	Yrs.		Jays	iouis		1-191		Mary	land Od. Inside City	
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urs affer de al', or items Examiner n	by Funeral	11. Marital Status 1 Never Married 2 A Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 MYes 2 ☐ I If Yes, Give Year or Dates:	∾ Na	vy 13.	Was Deceder If Yes, specify 1☐ Yes 2∑			n? (Specify Yes Puerto Rican, etc	or No- c.)		- America c, White, c		
De lied within /z hours after death with the marylat Hygiene. A Hygiene. Ad other then "natural", or items 23a or 28a-f ehow event, the Medical Examinat must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5	ō+)	(Give	dent's Usual C kind of work DO NOT use Oduce	done duri retired)	ing most o			Kind of Bus Santo		Mark	et
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00		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	temoval from State	- 1	ace of Dispo	osition (Name matory or othe edeeme	of er place)		Date 2/2004	20c.	Location - 0	City or To	wn, State	
epartment mportant I ny injury o		21. Signature of Funeral Service Licens	annen		22	2. Name and	Address	of Facility	Joseph a St.,	N.	Zann	ino	Jr. Fi	H 24
Physician /Medical		23a. Part1. Ent in the disease, or coind shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ications that caused ne cause on each li	the death ne.	Do not ent	brosis	of dying, s	such as ca	rdiac or respirat	ory arrest,			Approximate Interval Betwee Onset and De	een eath
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eair cermicate be executed attending physician and for use as the burial-transit	cal	resulting in death) Last	Due to (or as	a consequ	ence of):							n	noths.	
6 8	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic preg					23d. Date Mon		ry Day Yea	ar
s been signed by the should be detach	þ	Pan II. Dther significant conditions con Coronary Ar Diabetes				nderlying cau	se given i	in Part I.	23e.	Did tobacc			e cause of dea ably 4 □Unl	
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within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, et	ury - At ho c. (Specify	me, farm, str	reet, factory, o	office		28f. Local City of	ion (Street or Town, St	and Numbe ate)	er or Rurai	Route Numbe	r,
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within To th	Me	29b. Signature and title of certifier					icense n				Date signed			
+1		30. Name and address of person who co				Print)	047=	2.2 3	52/8	B	3-31-0	4		. [
Sta	ate	Kaien M. Piper, M. 31. Date filed (Month, Day, Year)	D 67.	O / /V rar'm Signat	. Cha	Nes St	- J	ute ?	52/8	Na	timore	mD	2120	4
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				For State AMEN	D ITEM #5	State of M PER FH G831	laryland 5/05/05	/ Depa JHCen	rtment of F	lealth <i>Death</i>	and Me		giene Reg. No. ⁴	2004	10	0041
		4		1. Decedent's Name	(First, Middle, La	ist)						2. Date of Dea Month	Day	Yeer		of Death
		Physici: /Medic			rgaret (March		2004		05PM
U	7	Examin		4a. Facility Name (II	not institution, giv	re street and number	7)		4b. City, Town, o	or Location	of Death		13	County of Deet	n ose	
		_		5. Social Security N	M 2000 umber U 6.5	1105/ Sex 7/A	ital ige (In yrs. las	t birthday)	If Under 1 Year		r 24 Hrs.	8. Date of Birt	h Manal	9 Birt	niece (Stat	te or Foreign
		Funeral Director		01/10		1□M 2¶F	80	Yrs.	Months Days	Hours	Min.	11/712/1	1923	PA	untry)	
	9	2 >		Usual Residence of	Decedent 10b. County		10c City	Town or Loc	ation						10d. Inside	City Limits
	Varyla	f shov	or	MD	Baltin	nore		edale							1 □ Y	es 2 No
	with the	3s or 28s-	i Direct	10e. Street and Nur 8352 Old	Philade	lphia Rd		· ·	10f. Zip Code 21237				_	en of What Co USA	untry?	
	d 21215-0036	o within 72 floors are local must be was year. Jiene. Then "natural", or Itams 23a or 28a-1 show the Medical Examinat must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☑ Widowed	ed 2 Married	12. Was Deceder Armed Forces 1Yes 2X If Yes, Give	s?] No	If	/as Decedent of I Yes, specify Cub ☐ Yes 25100	oan, Mexic	an, Puerto R	cify Yes or No- ticen, etc.)		4. Race - Ame Black, Whit Specify: W		ı
	21215-0036	stural cal Ex	ed b		15. Decedent's E			16a. Deced	ent's Usual Occu	pation			16b. Kin	d of Business/	Industry	
	215	Media	plet	(Speci	ify only highest gi ndary (0-12)	College (1-40	r 5+)	life. D	kind of work done ONOT use retire	ed)	st of workin	g		O II		
	2	Il Hygiene. other than	Con	17. Father's Name	(First Middle Loo			He	omemaker		her's Name	(First, Middle,	Maiden S	Own Ho	ne	
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10	, Mary	I and 2 should I Health and Men Item 27 Is marke other traumatic		19a. Informant's Na Darlene	ame/Relationship e Horney	(Type, Print) Daughte	er	19b. Mailin 1004	g Address (Stree Dellwoo	d Ave	enue F	alston	or, City or , MD.	21047	(ip Code)	
	D) -	of Health Item 27	1 3	20a. Method of Dis		Removal from Star	can	ce of Disponetery, crem	sition (Name of natory or other pla	ace)		ate		ation - City or		
5	ii g	ment ant: fi		° 4 ☐ Donation	5 ☐ Other (Spec	ity)	Metr		netory	j	3/31/	-	_	nsvill		
Clarth	Baltimore,	permit. Pages Deportment of the Important: If Ite any injury or of once.		21. Signature of Fu	neral Service Lie	msee		1	Name and Addr 211 Ches	aco A	""Cvac venue	h/Rosed Koseda	dale ale N	Funera Larylan	d 212.	9 37
U	硬			23a. Part1. Enter t shock, or hea	he disease, or con rt failure. List ont	mplications that caus y one cause on each	ed the death. line.	Do not ente	er the mode of dy	ring, such a	is cardiac or	r respiratory a	rrest,			mate Between nd Death
		hysician /Medical Examiner		Immediate Cause disease or condition resulting in death)	(Final on	- W	MON :									
			ner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nditions, nmediate arlying	b. Due to (or	as a conseque	ince of):								
R		be executed ician and burial-transit	Examiner	Cause (Disease or that initiated event resulting in death)	5	cDue to (or	as a conseque	ince of):								
	68760	93 95	cal		,	d				·····						
	P.O. Box 68	The law requires that the death certilica ate has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?		2 ☐ Fetal of tat time of dea	leath 3	Ectopic pregnant Other (specify)	cy			2	3d. Date of de Month	livery Day	Year
	С	ures that the de signed by the d be detached	by PI	Part II. Other signi	ficant conditions	contributing to death	but not result	ting in the u	nderlying cause g	iven in Pai	t I.			se contribute to		
	ord	w require been signal	ted	Chron	ic Ly	mphoc	ytic.	Leu	Bemia	1		10				Unknown
	e C	hasbe pe 2 sh	Completed	Deme	ntia,	Color	ary 1	1116	EY DI	sea	se,	24a. Was auto perfo	DSV	24b. Were a prior to death?	utopsy findi completion	ngs available of cause of
	E	n: The icate I		Hype	tens	on					(D)		2 No		2 No	
	∠ ≤	sician certifi irector	o Be	25. Was case refe examiner? 1 \(\text{Yes} \) 2	,	Hospital: 1 XInp	atient 2 TE	R/Outpatier	t 3 DOA O)th o r		<i>(Check only o</i> ne 5 □ Resi		i □Other (Spe	ecify)	
	of	g Phy er this eral d		27. Manner of Dea	th	28a. Date of 1 (Month,		28b. Time o	28c. Inj			28d. Describe			,,	
	Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigat 6 Could not determine	be 28e. Place of		ne, farm, sti		Yes 2		28f. Location (City or To		d Number or R	ural Route	Number,
	۵	Hospital o	edicai Cer	29a. Certifier (Check only	1 Certifying	Physician: To the be eminer: On the base	s of examination	eledge, deat on and/or in	n occurred at the vestigation, in my	time, date	and place, a leath occurre	and due to the ed at the time,	cause(s) date and	and manner a place, and du	s stated.	se(s)
_		o the ithin 2 o the smplei	Med	one) 29b. Signature and	d title of certifier	and manner	Alatou.		29c. Licer	nse numbe)r		29d. Dat	signed (Mon	th, Day, Yea	ar)
		+ 3 + δ		1	ion F.	Atule	MP		DO	05	772	1	9/2	7/04	/	
	-	5		30. Name and add	lress of person wh	no completed cause	of death (Item	23а) (Туре,	Print)	b		Ω	-/-	e Mo	717	27
		~		Dr Lau	ra Stee	1e,9000	ITan	Mlin	Squar	e Vi	ive,	Dalti	more	2, 1110	210	101
		St	tate	31. Date filed (Mo		32. Reg	istrar's Signati	11.0	60							

State of Maryland / Department of Health and Mental Hygiene 004 10042 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Yeer Marion V. Dixon 3 28 /Medical 2004 6:35 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3501 Howard Park Avenue Apt 204 N/A Balto If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country)
 MD **Funeral** 1 ☐ M 2 🗓 F Director 213-14-4365 81 2-18-1923 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at N/A Director 1 Yes 2 No Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3501 Howard Park Avenue Apt 204 USA 21207 Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 TNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black β 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) Social Security Administrative Clerk 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) Be if Health and Mental 2 Otho Holland Bessie Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurice Dixon - Son 2907 Tallowtree Road Woodstock, Md 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
sny injury or ot
once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 4/2/2004 Anne Arundel Co, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 21215 4300 wabash Avenue Balto, Md 23a. Patr1. Enter the disease, or complications that caused the 3-sth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart billium. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DIABETT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician ar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai 35 the attending 981 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has page 2 1 Yes 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 Yes 20 No Certification; To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pendina investigation 1 ☐ Yes 2 ☐ No To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Chack only one) within 24 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 127d75 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 750 Keistonston C LAUDIU LEVIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 01

		1	For State Registrar	State of M	aryland		rtment tificate			and M	R	eg. No. 4	004		043
Phy	/sicia		Decedent's Name (First, Middle, Last Ethel Louise Det								2. Date of Dear Month March		Year 2004	3. Time of 8:25	Death p M
/IV	ledica amine	al 4	a. Fecility Name (If not institution, give LongView Nursing	street and number)			Fown, or	Location o	of Death			ty of Death		
Fund			. Social Security Number 6. Se 20–16–0643	x 7. A	ge (In yrs. Ia 79	st birthday) Yrs.	If Under Months		If Under	24 Hrs. Min.	8. Date of Birth Month, Day NOV • 2	1°, 1924	9. Birth	olece (State onto) Land	ir Foreign
and	72	H	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation	-						10d. Inside C	
Maryle-1 sho	politied	cto	Maryland Carroll			Manche						Og. Citizen o	What Cou		2 XNo
with the	2	Director	10e. Street and Number 2311 Bachmans Val	ley Rd.			10f. Zip	2110a	2				5.A.	in y :	
36 s after death or Items 23	amingr mile	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	? [No		Was Deced f Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No- Rican, etc.)	14. R B	ace - Ameri ack, White,		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or Items 23a or 28e-1 show	Medical Ex	Completed b	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	ucation		life.	dent's Usua kind of wor DO NOT us	rk done d se retired	during mos)	t of work	ing	16b. Kind of	Business/Ir	-	
and 21 d be filed wental Hygier	c event, the	o Be Cor	17. Father's Name (First, Middle, Last) H. Walter Mil	ler	1						e (First, Middle, a Flore)	Maiden Sum	ame)		
Taryl 2 should and Me	raumati	င္	19a. Informant's Name/Relationship (1 Larry Rohrbaugh -		7.						al Route Numbe ncheste:				
nore, Nages 1 and nt of Health	y or other t	1	20a. Method of Disposition 1 Burial 2 Cremation 3 1 Donation 5 Other (Specify	Removal from Stat		lace of Dispo emetery, crea	osition (Nar matory or o	ne of ther plac	(6)		Date	20c. Locatio	n - City or T	own, State	
Baltin permit. P. Departme Important	any injury		21. Signature of Funeral Service Licen	ent x		£3	Name ar Ckharc 296 Cl	d Address	ss of Facility unera il Dr	I Ch	apel P.	A. r, Md.			
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	rector, pag	Be C	25. Was case referred to medical examiner?	Hospital:				Ott			th (Check only		011 /0	-4.1	
of Vital	eral dire	7: To	1 Yes 2 No 27. Manner of Death	28a. Date of I		28b. Time Injury		OA 28c. Inju Wo	4	lursing H	ome 5 ☐ Resi 28d. Describe			cily)	
Division or Attending after death.	To the runeral Director: After this certific completely filled in by the funeral director,	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not to determined	n 28e. Place of		ome, farm, s	М	1 [Yes 2]No	28f. Location (City or To	Street and No wn, State)	ımber or Ru	ural Route Nu	ımber,
the Hospitel on the Abours at	runerai L	Medical Ce	29a. Certifier Check only 2 Medical Exa	hysician: To the be miner: On the base and manne	s of examina	owledge, dea ation and/or	ath occurred investigatio	d at the t	me, date a opinion, de	and place aath occu	, and due to the irred at the time,	cause(s) and date and pla	I manner as ce, and due	stated. to the cause	ı(s)
To the	сотріє	Me	29b. Signature and title of certifier	Sun	VA.		29	_	se number			29d. Date s	gned (Mont	h, Day, Year)	
F			30. Name and address of Arson and	completed cause	of death (Ite	m 23a) (Type	1.1	مبده	P-1	e.	· Cank	steel	w	2210-	24
F	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Reg	pistrar's Sig	ature	J.	Spe	NE S	-	,				

		-	For Stete Registrar	State	of Maryla	nd / Depa	artmei rtifica	nt of H	lealth a	and M	lental Hy	giene Reg. No	20	04	1004	4
	Dhunini		Decedent's Name (First, Midd)	e, Last)							2. Date of De Month	eath Da	v	Year	3. Time of Death	
	Physicia /Medic		William		ienico						3	30	2	400	10 32 AN	4
	Examin	er	4a. Facility Name (If not institution			e .			Location			1	County	of Death		
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	Funeral		5. Social Security Number	6. Sex 1⊠ M 2 ☐ F		i. last birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da	ay, Year,		Coun		n
	Director	1	219-30-7245 Usual Residence of Decedent	71	69			L			AUG 10	, 1	9.34_	Mary	Land	_
	/land		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10	Od. Inside City Limits	š
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	dea	ner	11. Marital Status	12. Was De Armed F	cedent Ever in l	U.S. 13.	Was Dece	edent of H	ispanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)	o-		e - America		
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ar _Z	shour nd M mar		19a. Informant's Name/Relations			19b. Maili	ng Addres	s (Street			I Route Numb			State, Zip	Code)	_
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o C	of He		20a. Method of Disposition	2 🗆 🗆 🗆		Place of Dispo cemetery, cre	osition (Na matory or	me of other plac	:ө)	C	ate	20c. L	ocation -	City or To	wn, State	
Ĕ	Page nent ant: If		1 ☐ Burial 2 【Cremation 1 ☐ Donation 5 ☐ Other (5		Me	tro Cre	emato	ry In	nc.	3-31-	-04	Ва	Ltimo	ore, l	MD	
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medica	ng Physician: To to Examiner: On the	basis of examin	nowledge, deat nation and/or in	th occurre ovestigation	d at the tin n, in my o	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s date an	and ma d place,	inner as stand due to	ated. the cause(s)	
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	140		30. Name and address of persor	who completed ca	use of death (Ite	em 23a) (Type		000	000			*50	- (-	30 / (7	_
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	Regist	rar	400 01 2	nna lan	411	12	14000	RO								

		For State Registrar	State of Ma	aryland / Depa	artment of H			iene 2001	10045
Physicia	ın	1. Decedent's Name (First, Middle, Last) Gilbert Cheste	er Detter				2. Date of Death March	38 ^{ay} 20 64	3. Time of Death 2:10 p M
/Medic Examin		4a. Facility Name (If not institution, give st LongView Nursing 1			Man	r Location of Death chester		4c. County of Death	1
Funeral Director		212-10-2507	M 2□F	83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day March 2	9. Birth Cor Mar	plece (State or Foreign into) y Land
Maryland I-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll		10c. City, Town or Lo	ocation nester				10d. Inside City Limits 1 ☐ Yes 2 🌠 No
with the 3a or 28s	i Director	10e. Street and Number 2311 Bachmans Val	ley Rd.		10f. Zip Code 211	02	10	0g. Citizen of What Cor	untry?
paritimore, interpretable 212.13.0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madical Exertime found be notified at ange.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent I Anned Forces? 1 DYes 2 N If Yes, Give Year or Dates:	No.	Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.
vithin 72 hounder.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5	(Give	dent's Usual Occup kind of work done DO NOT use retired Truck Dri	during most of work d)	ing	16b. Kind of Business/I	ndustry
Id be filed wents Hygier the count, ID	To Be Col	17. Father's Name (First, Middle, Last) Maurice Detter				18. Mother's Nam	e (First, Middle, M		
Nicity nd 2 shou tith and M 27 is mar r traumat		19a. Informant's Name/Relationship (Type Larry Rohrbaugh - 1						City or Town, State, 2 Md. 2110	
Pages 1 alent of Hez		20a. Method of Disposition 11 Burial 2 Cremation 3 Re 14 Donation 5 Other (Specify)	emoval from State	20b. Place of Disposementary, cre New Luthe	osition (Name of matory or other planer)	April 2,		20c. Location - City or Manchester	
parmit. Pages permit. Pages Department of Important: If it any injury or of		21. Signature of Fugeral Service License	Ď	E23	Managradi Addio 296 Charm	tineral Ch il Dr. Ma	apel P.A nchester	, Md. 2110	2
Pnysician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	ations that caused e cause on each lin	ne.	iter the mode of dyli	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
/Medical ate be executed hysician and the burial-transit	licai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of): a consequence of);					
Cords, P.O. BOX bx wrequires that the death certificates signed by the attending phy should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y		23d. Date of del Month	ivery Day Year
ords, P.	þ	Part II. Other significant conditions con	(out not resulting in the	underlying cause gr	ven in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
The lay	Completed							sy prior to death? 2 No 1 Yes	utopsy findings available completion of cause of
VISION Of VITAL IN Attending Physicien: The relath. ector: After this certificate by the funeral director, pag	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpati 28a. Date of Inju (Month, Da	ury 28b. Time Injury	of 28c. Inju	her: 41 Nursing H		ne 6 □Other (Spe ow injury occurred	city)
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	ijury - At home, farm, s rtc. <i>(Specify)</i>	treet, factory, office		28f. Location (S City or Tow	Street and Number or Ri m, State)	ural Route Number,
DIVI To the Hospital or At within 24 hours after d within 24 hours after d to the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) Check only one) Check only one)	sician: To the best ner: On the basis of and manner st	of examination and/or	ath occurred at the tinvestigation, in my	ime, date and place opinion, death occu	rred at the time, o	cause(s) and manner as date and place, and due	o to the cause(s)
To the within To the comp	X	29b. Signature and title dicertifier	\sim	W N	29c. Licen	37145	-	29d. Date signed (Mont	
5		30. Name and address of person who co			e, Print) Pike Ha	mpstes 2	ne 5 m	21074	
St Regist	ate trar	31. Date filed (Month, Day, Year)		trar's Signature	1. do	de .			

			1 - For State Registrar		State of Ma	arylan	d / Depa <i>Cei</i>	artment of I rtificate of	Health Deat	n and I th	Mental Hy	/gien Reg. N		14	1004	(
	Physici	an	1. Decedent's Name (First, M	iddle, La	st)						2. Date of Do		ay Yea		Time of Death	
	/Medic		BETTY DAVE								MAR	24	2004	000	7:15 M	_
	Examin	er	4a. Fecility Name (If not instit. UNIVERSITY OF P 5. Social Security Number		AND HEDICAL		EMS	4b. City, Town, of BALTIM If Under 1 Year	ORE				c. County of De			
- '	Funeral Director		PA 38 5184 Usual Residence of Deceden	1	_M 2₫ F	65	Yrs.	Months Days	Hour		8. Date of Bi (Month, D 05 - 27	ay. Year	18	Country)	(State or Foreign	1
	yland		10a. State 10b. Cou			10c. City	y, Town or Lo	cation						10d. lr	nside City Limits	_
	B Mar	ctor	MD	NA		BAL	TIMORE	=						1	XYes 2 □ No)
	or 28	Dire	10e. Street and Number					10f. Zip Code				10g. C	itizen of What (Country?		
	s 23a	ral	1612 BRADDIS	HA	VENUE	e	0 100	212		0::0/0			USA			_
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or Items 23a or 28e-f e-how any injury or other treumatic event, the Mardinal Examinar must be notified at anone.	by Funeral Director	11. Marital Status 1 Never Married 2原 I 3 Widowed 4 Divor		12. Was Decedent Armed Forces? 1 Yes 2 4 If Yes, Give Year or Dates:		1	Vas Decedent of I f Yes, specify Cub I ☐ Yes 2 LNo	rispanic an, Me xi Spec	can, Puerti	pecity Yes or No o Rican, etc.)	0-	14. Race - An Black, Wh Specify: B			
2-0	72 ho	ted	15. Dece (Specify only hi	dent's Ed	ducation		16a Deced	lent's Usual Occup	ation	and of war	tina	16b. I	Kind of Busines			
21215-0036	filed within Thygiene. Hygiene. other then "cont, the Man	Completed	Elementary/Secondary (0-1 12-134 GRADE		College (1-4or 5	i+)	INSPE	kind of work done DO NOT use retire	d)	lost or wor	King	DE	FENSE	CONT	TRACTOR	
Maryland	be file of oth	Be	17. Father's Name (First, Mid)						ne (First, Middle					
7	should be not Mental marked c	ို	OLIVER OWEN 19a. Informant's Name/Relat		Tuna Printl		10h Mailie	a Address /Street	L		UE JOH			7:- 01	-1	_
S	and 2 sho salth and n 27 is m		PAM STANTON		туре, гтиц			g Address (Street MILFORD			D. PIKE			SOL	9) 202	
re,	es 1 an of Heal fitem 2 r other		20a. Method of Disposition			20b. P	lace of Dispo	sition (Name of natory or other pla			Date		ocation - City o	- 4	State	
altimore,	Pages nent of I		1 Burial 2 Cremati 4 Donation 5 Othe				JID BIE		<i>C</i> 6)	04-0	2.04	PIKE	SVILLE	, MD)	
Balt	permit. Departm importa any inju		21. Signature of Funeral Sen	ice Licer			VA VA	Name and Addre UEHN C. (51 BALTO.	SS of Fa	CILITY F	UNERAL	SE	2NICE 21229	3		
	1 13.		23a. Part1. Enter the disease shock, or heart failure.	, or com List only	plications that caused one cause on each lir	the death								Арр	roximate rval Between	_
	Physician		Immediate Cause (Finat disease or condition	Ossa	a CHRONIC										et and Death	
	/Medical Examiner		resulting in death)		Due to (or as											
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Ŏ.	t the c by the	hysi	9 Unknown		9□ Unknown											
rds, P	w requires that been signed should be det	by	Part II. Other significant con	ditions c	ontributing to death be	ut not resu	afting in the ur	iderlying cause giv	en in Pa	rt I.			use contribute		use of death? 4 □Unknown	
Vital Record	G 2 C	Completed	<u></u>								24a. Was auto perfo	psy rmed?	prior to death?	completi	ndings available ion of cause of	
/ita	ding Physicien: The Ih. h. After this certificate he funeral director, page	Be	25. Was case referred to med examiner?	lical						ace of Dear	th (Check only					
of	Physi this c al dire	70	1 Yes 2 No		Hospital: 1 Inpatie		ER/Outpatient		4	Nursing Ho	ome 5 Resi			ecify)		
ono	ding I h. After funer	tion:	1-■Natural 5 Pe	nding estigation	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2	ΠNo	28d. Describe	how inju	ry occurred			
Division	or Atten after deat Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be ermined		ry - At ho c. (Specify	me, farm, stre		103 2		28f. Location (City or To		nd Number or F	Rural Rou	te Number,	-
۵	pitel o		20a Carifiar 197 Cari	huina Oh	voiden. To the book	-4 1										
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medi	cal Exan	ysician: To the best on niner: On the basis of and manner sta	examinat	wiedge, death ion and/or inv	estigation, in my o	pinion, d	eath occur	and due to the	date an	d place, and du	e to the o		
)	Viii Cor	-	29b. Signature and title of cer	III ler				29c. Licens				29d. Da	ite signed (Mon	ith, Dey,	Year)	
	10		30. Name and address of per	on who	Completed cause of de	H I			642	>		HI	4R 26,	20	04	
	4		WEN-YEE To				REENE		3A/ T	MORE	MD	フロ	1201			
泰	Sta		31. Date filed (Month, Day, Yo	ear)	32. Registra	r's Signat		1 1	116	1	FIV	4	1201			_
32	Registr	ar		AF	PR 0 1 2004		Color	St. Age	MAN S	0						

	1	For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H rtificate of I			giene 100, No. 200	
Physiciar	ו	. Decedent's Name (First, Middle, Last) BOBBY S . DENS	SON				2. Date of Dea MARCH 2	24, Day 2004 Year	3. Time of Death 02:40 a.M
/Medica Examine		a. Facility Name (If not institution, give st MEMORIAL HOSPI			CUMBERLA			4c. County of De	Y
Funeral Director		Social Security Number 246-30-9152 Sual Residence of Decedent	M 2□F	(In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day AUG. 3,	(, Year)	irthplace (State or Foreign Country) RTH CAROLINA
Maryland a-f show	1	Oa. State 10b. County WV MINERAL		10c. City, Town or Li KEYSE					10d. Inside City Limits 1 X Yes 2 No
h with the	5	0e. Street and Number 625 REYNOLDS TERI	RACE		10f. Zip Code 2672	26		10g. Citizen of What (Country?
rs after deat	by Funeral		2. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ※ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Wi	nerican Indian, nite, etc. VHITE
paritimities into yield yield at 12 12 12 12 12 12 12 12 12 12 12 12 12	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) Coilege (1-4or 5-	16a. Dece (Give life.	dent's Usual Dccup kind of work done of DO NOT use retired	during most of work	king	16b. Kind of Busines UNITED ST	
d be filed we antal Hygier to covent, the	10 Be Cor	7. Father's Name (First, Middle, Last) SAMUEL LELAND DEI	NSON	PRI	NTER		e (First, Middle, ELIZABET	(CIA) Maiden Sumame) TH BUNN	
Mail y lating d 2 should be file th and Mental Hy 27 is marked oth traumatic event		19a. Informant's Name/Relationship (Type SUSAN DENSON/ WIF	oe, Print)		ing Address (Street	and Number or Rui		r, City or Town, State	
callinote, mit. Pages 1 an partment of Heal portant: if Item 2 y injury or other	2	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)		20b. Place of Disp	osition (Name of ematory or other place	ce) M	Date ARCH 25 2004	20c. Location - City	or Town, State
Dermit. Departm Importa any inju	Market	21. Signature of Funeral Service License Busin F. 4	Intello	2	2. Name and Addre	ss of Facility S	MITH FUN KEYSEI	NERAL HOME	
cate be executed /Medical Examiner et and the bruighten and the pringitude of the principle	ıminer	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					Interval Between Onset and Death
that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	□Ectopic pregnancy	/		23d. Date of o	delivery Day Year
igne igne	ď,	Part II. Other significant conditions con	tributing to death bu	t not resulting in the	underlying cause giv	ren in Part I.			to the cause of death? Probably 4 □Unknown
The law ate has b page 2 si	Completed						24a. Was autop perfo 1 □ Yes	rmed? prior to death	autopsy findings available to completion of cause of ? es 2 \(\square\) No
VIIC sician certific	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital:	nt 2 🗆 ER/Outpatie	ent 3 DOA Oth	26. Place of Dea	A 5 2000	ne) dence 6 □Other (S	pecify)
Attending Physic death. The death. Sector: After this by the funeral di	ation:	27. Manner of Death 1 Manual 5 ☐ Pending investigation	28a. Date of Injur (Month, Day	y 28b. Time Year) Injury	Wo	yat rk? Yes 2 □ No		now injury occurred	
UIVISION tal or Attending ts after death. al Director: Afte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ry - At home, farm, s . (Specify)	treet, factory, office		28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
Hospi 4 hou Funer ely fill	Medical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	sician: To the best oner: On the basis of and manner sta	examination and/or i	nvestigation, in my o	ppinion, death occu	rred at the time,	cause(s) and manner date and place, and o	lue to the cause(s)
To the l		29b. Signature and title of certifier	/	and the control	29c. Licens D1438			29d. Date signed (MC MARCH 2-4	onth, Day, Year) - , 2004
Stat		30. Name and address of person who co Augusto Figueroa M 31. Date filed (Month, Day, Year)	.D. 625 K	ent Avenue	e Cumberla		land 215	502	
Registra	-	APF	0 1 2004	A Signature	is how	acc.			

		4	For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of H rtificate of I	lealth and M Death		giene 2004	10048
	Physicia		1. Decedent's Name (First, Middle, Last, MICHAEL			ÞĒ	ELUCA	2. Date of Dea Month March	Day Year	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give		CAL CENTER		Location of Death		4c. County of Dea	n/A
	Funeral Director		5. Social Security Number 6. Se	7. Ag	ge (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	Hours Min	8. Date of Birtl (Month, Day Aug • 13	9. Bir (, Year) Co (, 1912 NO:	thplace (State or Foreign bunity) rth Carolina
	show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation	Dunda	. 11-		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the N a or 28a-f be rollfi	Director	Maryland Baltin	nore		10f. Zip Code	21222		10g. Citizen of What Co	
36	2 should be filed within 72 hours after death with the Marylend and Memlar Hygene. Is marked other then "neturel; or items 23a or 28a-f show aumatic event, tre Modical Examinations to cliffed at	by Funeral	102 Shipway 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 the Yes, Give Year or Dates:	? tNo	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (Sp	ecify Yes or No- Rican, etc.)	Black, Whi	
Maryland 21215-0036	thin 72 hour e. en "neturel' Modical Ex	Completed b	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	ıcation	16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	during most of work d) 		16b. Kind of Business	/Industry
_	m = 0 5	Be	8 Years 17. Father's Name (First, Middle, Last) Frank DeLuca		Re	staurant	18. Mother's Nam	vner e (First, Middle, armela B	Restau Maiden Sumame) Sorelli	rant
Maryle	d 2 should th and Mer t7 Is marke traumatic	은	19a. Informant's Name/Relationship (T Dr. Frank DeLuca						or, City or Town, State,	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic et <u>once</u> .		20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3 □ 1 1 □ Dopetion 5 □ Other (Specify,		an I	osition (Name of matory or other place nislaus C	ce)	Date 31/2004	20c. Location - City or Dundalk,	Town, State Maryland
Balti	permit. Departn Importa any inju		21. Signature I vaneral Service Lines	Ful	1011 7	922 Wise	Ave. Dur	ndalk. M	Dundalk, I Maryland 2	1222
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a SEPS	IS	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner	er	Sequentially list conditions	b. HEAR	s a consequence of): RT A TTACK e a consequence of):					ONE MY
8760,	cate be executed physician and the burial-transit	dicai Examiner	It any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):					
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy	<i>y</i>		23d. Date of de Month	livery Day Year
<u>α</u>	quires that n signed by ald be deta	d by Ph	Part II. Other significant conditions co	ntributing to death	but not resulting in the	underlying cause giv	ven in Part I.	1	obacco use contribute t Yes 2⊠No 3□P	o the cause of death? robably 4 DUnknown
Vital Records,	The law requir ate has been si page 2 should	Completed						24a. Was autop perfo 1 □ Yes	an 24b. Were a prior to death? 2 No 1 Ye	utopsy findings available completion of cause of s 2 No
Vita	Physicien: The raths certificate har all director, page	Be	25. Was case referred to medical examiner?	Hospital:		-t 3 Doa Ott	26. Place of Dea		one) dence 6 □Other (Spe	noifu)
Division of	ding Ph h. After th funeral	tion: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	iury 2 ER/Outpatie jury 28b. Time lnjury	of 28c. Injur	4 Nulsing in		how injury occurred	эслу)
Divis	i Çife	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	200. Flace of it	njury - At home, farm, s etc. <i>(Specify)</i>	treet, factory, office		28f. Location (3 City or Tox	Street and Number or F wn, State)	lural Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edicai	(Check only 2 Medical Exemone)	ysician: To the besinner: On the basis and manner s	st of my knowledge, dea of examination and/or i stated.	nvestigation, in my o	opinion, death occur	rred at the time,	cause(s) and manner a date and place, and du 29d. Date signed (Mon	e to the cause(s)
ŀ	with To	×	29b. Signature and title of certifier	& Fo	Brull me	<u> </u>	ES-00		_	28,2004
	8		30. Name and address of person who poets & ANAND PAREKH, 4				IEW MEDICAL	CENTER, E	BALTEMORE, MAR)	remo 5,21224
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regis	strar's Signature	books				

			For	State of Mar	yland / Depa	artment of	Health and	Mental Hy	giene	
			1 - State Registrar		Ce	rtificate of	Death	!	Reg. No. 200	4 10049
	Physici	an	Decedent's Name (First, Middle, Last,					2. Date of Dea	ath Day Yee	3. Time of Death
	/Media		MARION RUBY SWA	IN ELDER				March		M
	Examir	ier	4a. Facility Name (If not institution, give Riverview Nursing			1	or Location of Dear ce County		4c. County of De Balti	
	Francis		5. Social Security Number 6. Se		In yrs. last birthday)					
	Funeral Director			™ X XF 71	•	Months Days		8. Date of Birt (Month, Da)	y, Year) 4, 1932 Vi	irthplace (State or Foreign Country)
	p.		Usual Residence of Decedent					1000. 2	7, 1002 VI	
	anylar show	5	10a. State 10b. County 10h. County 1		0c. City, Town or Lo Rald	timore Co	ounty.			10d. Inside City Limits 1 ☐ Yes 2 🗶 No
	the M	ecto	10e. Street and Number	,	Dati				100 000-000	
	tiled within 72 hours after death with the Maryland Hygiene. sther than "natural", or Itams 23a or 28a-1 show ent, If a Mucilcal Exartiner must be rediffed at	Completed by Funeral Director	400 Crisfield Rd.			10f. Zip Code	21220		10g. Citizen of What C	•
	ms 23	era		12. Was Decedent Eve	er in U.S. 13.	Was Decedent of		Specify Yes or No-		
9	after or Ital	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give		If Yes, specify Cul	Hispanic Origin? (S pan, Mexican, Puer	to Rican, etc.)		
93	ours rral', c	d by	XX Widowed 4 ☐ Divorced	Year or Dates:		1 Yes 21 No	Specify:		Specify: W	nite
2	natu	ete	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occu kind of work done	during most of wo	rking	16b. Kind of Busines	s/Industry
12	withir ene. than	dmo	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+) N/A		<i>DO NOT u</i> se <i>retir</i> e Emaker	9 <i>a)</i>		Homomakin	g ~ Own Home
о 5	Hygic Hygic Sther	ပိ	17. Father's Name (First, Middle, Last)	IN/ PA	ПОШЕ	SIIIGKET	18. Mother's Na	me (First, Middle,	Maiden Sumame)	y ~ Own nome
lan	ld be ental ked c	To Be	Allie Poland Swair	1			Wesle	y Evelyn	Bennett	
Maryland 21215-0036	should be and Mental is marked o	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailii	ng Address (Stree	t and Number or Ri	ural Route Numbe	r, City or Town, State,	Zip Code)
	and 2 ealth a n 27 ls		Roy P. Elder, Jr.	(Son)	3716	Seneca 0	Gardens R	d. Balti	more, Md.	21220
ore	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R			matory or other pla		Date	20c. Location - City of	
Ë	. Pages tment of tant: If Its jury or o		'4 □Donation 5 □ Other (Specify)		Gardens d	of Faith	Cem. 4~2	~2004	Baltimore,	Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, if a Mudical Examiner must be notified at once.		21. Signature of Funeral Service Licensi	in Char			ໜື່າຍໍ່ເລີ່ໄ Ho ir Rd. Ba		, Md. 21230	6
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	-	er the mode of du	ing cuch ac cardia.	or respiratory as	rost	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Lung	7 Con	er w	ith B	rain N	Pelastaris	Onset and Death
8	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):					
	LAdilille	<u>.</u>	Sequentially list conditions, if any, leading to immediate). ————————————————————————————————————						
)	ted nsit	nine	Cause (Disease or injury	Due to (or as a c	onsequence or):					
3	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					
760,	te be executed ysicien and e burial-transit	cal		1.						
Вох 68	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medi								
× ox	th cer tendir ir use	an/h	230. was decedent pregnant	3c. If yes, outcome of p		Ectopic pregnanc	:v		23d. Date of de	,
	e dea the at	sici	in the past 12 ponths? 1 ☐ Yes 2 2 No 9 ☐ Unknown	4☐Pregnant at tim 9☐ Unknown		Other (specify)			Month	Day Year
<u>d</u>	hat th ed by detacl	Ph)	Part II. Dther significant conditions cor	stributing to death but of	ot resulting in the u	nderlying cause or	ven in Part I	23e Did to	bacco use contribute	to the cause of death?
Division of Vital Records, P.O.	signe d be	d by	Anemia,	11 1	Hypord	1				robably 4 Unknown
00	w requestion	Completed			7.00	,- ,-	111	24a. Was a	24b Wess o	utopsy findings available
Re	rsician: The law s certificate has b lirector, page 2 s	duic						autop: perfor	sy prior to death?	completion of cause of
ta	an: T tificat tor, pa	0	25. Was case referred to medical				26 Place of Dec	1 ☐ Yes	21 No 1 Ye	s 219No
<u> </u>	ysici is cer direc	To B	examiner?	lospital:	2 ER/Outpatien	t 3 DOA Ott			ence 6 Other (Spe	əcifv)
0	ding Phys		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Inju Wo			ow injury occurred	//
Sio	andii eath. or: Al	atic	2 Accident investigation				Yes 2□No			
Ž	l or Attano after death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (5		eet, factory, office		28f. Location (Si City or Town	treet and Number or Fi n, State)	lural Route Number,
	pital ours a eral C		29a. Certifier 1 Certifying Phys	iniana Taraha bana at m						
	To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only 2 Medical Exemination)	sician: To the best of m ner: On the basis of ex- and manner stated	amination and/or inv	vestigation, in my	me, date and place opinion, death occu	red at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	Го th within Го th	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mon	th, Day, Year)
			> ATP MD			D	-387	54 0	03-30	-2004
	10		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	Print)	0.0.1	Alia	110	-2004
	IV		MALIKA WAS	BEM.	to4.	BAST	ERN	USLVD	- 1010	
	Sta Registr	40	31. Date filed (Month, Day, Year) APR 0 1 201	32. Begistrar's	Signature	reals 8 "				

		1	For State Registrar		State of	Marylar		artment of		nd Mental Hy		2004	10050
/Me	siciar edica minei	1	Decedent's Name (First Anton a. Facility Name (If not in		street and num	1		-leise			Day 21	Year 200 4 unty of Death	3. Time of Death 2:04 am
Fune Direc			The Shn. Social Security Number 215–14–0273 Isual Residence of Dece	1]		7. Age (In yrs.	last birthday) Yrs.	Bâltime If Under 1 Year Months Days	If Under 24	Hrs. (8. Date of B (Month, D 03/07)	iπn Pay, Year)		e City place (State or Foreign nany
the Maryland 28e-f show	Director	1	0a. State 10b.	County Harford	E		ity, Town or Lo	10f. Zip Code			10g Citizen	of What Cour	Od. Inside City Limits 1 ☐ Yes 2 No
1215-0036 within 72 hours after death with the Maryland one. than "netural", or Items 23s or 28e-1 show	hy European Di	1	3929 Houc	[X Married	12. Was Dece Armed For 1 (XYes If Yes, Give	ces? 2 [] No e		21111	Hispanic Origin ban, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	U.S		ean Indian, etc.
21215-0036 ad within 72 hours af gjene. er than "netural", or	d betelemon		15. D	ecedent's Edi y highest grad	Year or Daucation de completed) College (1:		16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	during most o	of working		of Business/Ind	dustry
Maryland 2 d 2 should be filed of the and Mental Hygical Strie marked other transmits over the strings of the	ToBol	מ מ	7. Father's Name (First, Anton Fleis 19a. Informant's Name/Ri	schman	ype, Print)		19b. Maili	ng Address (Stree	Kathe	s Name (First, Middle Prine Feic or Rural Route Numi	ertag		Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural; or Items 23a or 28e-1 ehow any inter or other transfer word.	once.	2	Barbara Fle Oa. Method of Disposition 1	mation 3 Dither (Specify, Service Licens	Removal from S	State St.	Place of Dispondent Place	estion (Name of matory or other pla e Evangeli 2. Name and Addr 1750 Bel	st Cem.0 ess of Facility air Roa	Date 4/02/2004 E. F. La ad – Kings	Hyde Hyde ssahn ville,	on City or To es, Mar Funera	yland 1 Home, P.A 1087
https://www.physician and physician and physician and physician and st he huria-transit	eal ner	ical Challiller	shock, or heart failu mediate Cause (Final disease or condition esulting in death) Sequentially list condition any, leading to immedia cause. Enter Underlying ausse (Disease or miguy hat infitated events esulting in death) Last	(a. Se Due to Due to (c. Cf)	1	quence of):) e				-	Interval Batween Onset and Death Dea
Cords, P.O. Box 68 wrequires that the death certifica been signed by the attending ph should be dearched for use as th	hy Dhyslylan/Mad	lysicial bridge	F FEMALE: 23b. Was decedent pregr in the past 12 month 1 Yes 2 No 9 Unknown	nant		nth 2 ☐ Feta ant at time of	al death 3	Ectopic pregnand Other (specify)	су		23d.	Date of delive Month	ory Day Year
I Records, P.O. Box 68 The law requires that the death certifica stehas been signed by the attending phanes 2 should he detailed for use as it.	Completed by D		and 11. Other significant of COTODAC	conditions	ery d	isea:			iven in Part I.		Yes 2 □ No	3 Prob	ably 4 Dunknown
Vita vicien: certifica	To Be Com	2	25. Was case referred to examiner?	-	ellit	rpatient 20]ER/Outpatier	nt 3 DOA	thor		ormed? 2 D No one)	death?	2 DNo
Division of Vital or Attending Physicien: after death. Director: After this certification by the fundral director.	. doltasijitas		2 Accident	Pending investigation Could not be determined	28e. Place	h, Day Year)		We	ork?]Yes 2 □ No	28f. Location			l Route Number,
DIVI To the Hospital or At within 24 hours after a To the Funeral Direct completely filled in by	Modical Co	edical	29a. Certifier 1 2 1 2 1 N one)	fedical Exam	rsician: To the iner: On the ba and mann	isis of examin	owledge, deat ation and/or in	vestigation, in my	ime, date and popinion, death	place, and due to the occurred at the time	, date and place	manner as st ce, and due to gned (Month, i	the cause(s)
17			0. Name an a dress of	ù M		M D e of death (Ite	A 1 1 1	RES	5 - 00 + B	0	March	h 29,	2004
Reg	State	*	Les II e B1. Date filed (Month, Da	y, Year) APR		egistrar's Sign	North	Spend of		altimore,	Maryle	anci d	100/
							ORIGIN	IAL					

			1 - For Amend Item 25 per Registrar	States of Mandan	AdiBep Ce		Health and	F	giene Reg. No.	2001	10051
İ	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) E' MONY 4a. Fecility Name (If not institution, give s	otreet and number)	41	0 11:	or Location of Dea	2. Date of Dez Month Murch	Day		3. Time of Death
	Funeral Director		5. Social Security Number 6. Sex 2 0 3 - 1 0 - 7 0 9 7 Usuel Residence of Decedent	M 2 F 7. Age (In yrs. It	Yrs.	If Under 1 Year Months Days		1. (Month, Day	v, Year)	9. Bird	hplece (Stete or Foreign untry) Pennsylvat
	with the Marylar n or 28a-f ehow	Director	Pa. York 10e. Street and Number		, Town or Lo	10f. Zip Code			10g. Citi	zen of What Co	10d. Inside City Limits 1 ☐ Yes 2√ No untry?
020	be filed within 72 hours efter deeth with the Maryland the Hygiene. All Hygiene. Al	by Funerai	2126 Bayberry 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1				Specify Yes or No- no Rican, etc.)		USA 14. Race - Ame Black, White Specify:	
9200-612121	filed within 72 ho Hygiene. other than *natur ent, tre Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+) +4	(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of w		ПЗ	of Business/	Industry
Maryland	d 2 should be filed within th and Mental Hygiene. If is marked other than treumatic event, the M	To Be	17. Father's Name (First, Middle, Last) Amos M. Funk 19a. Informant's Name/Relationship (Typ.	oe, Print)	19b. Maili	ng Address (Street	Edit	ame (First, Middle, M. Coll Rural Route Number	rmar	٦y	lip Code)
a)	1 an Heal Hem 2 Ither		Devona R. Funk 20a. Method of Disposition 1	emoval from State	ace of Dispo metery, crea	26 Bayb sition (Name of matory or other pla Funera	ce)		20c. Lo	a. 1740 cation - City or	Town, State
Balt	permit. Peges Depertment of important: If if eny injury or o		21. Signature of Funeral Service License	cations that caused the death	22	Name and Address	ess of Facility ok Road	Ruck Tows Towson.	on F MD		Home, Inc.
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e cause on each line.	ence of):	Shock	em fa	ilure		Tract	Interval Between Onset and Death Lday Zday 3 - L S
DOX 68/00,	death certificate be executed e attending physicien and od for use as the burial-transit	icai	that initiated events resulting in death) Last c. IF FEMALE: 23b. Was decedent pregnant 23	Due to (or as a consequence of pregnance). If yes, outcome of pregnance of pregnanc	ence of):			144 621 1410	_	3d. Date of delin	yarv
	at the deat d by the atte etached for	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fetel 4 Pregnant at time of de	ath 5□	Ectopic pregnancy Other (specify)				Month	Day Year
ecolos,	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions cont	ributing to death but not resul	lting in the u	nderlying cause giv	en in Part I.	23e. Did tot	pa .		the cause of death?
	The ate h page	e Completed	25. Was case referred to medical				26 Place of De	24a. Was a autops perform 1 Yes 2	Tod2 2 LXNo	24b. Were aut prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
5	ding Phys	ertification: To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		PVOutpatien 28b. Time of Injury	28c. Injur Wor	er: 4 □ Nursing I y at	Home 5 Reside	ence 6		(fy)
DIVISION	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	O	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	rledge death	Occurred at the time	ne, date and place	City or Town	7, State)		ral Route Number,
	To the Ho within 24 h To the Fu completely	Medical	(Check only 2 Medical Examination) 29b. Signature and title Acertifier	er: On the basis of examination and manner stated.	on and/or inv	29c. Licens	pinion, death occ	urred at the time, da	ate and p	signed (Month,	to the cause(s)
	Sta Registr	_	30. Name and address of person who con PRECTI JOHN GOO 31. Date filed (Month, Day, Year) APR 0 1 2004	NORTH WOL 32 Registrar's Signatu	FEST	Print)	ALTIMO		ARI	TLAND	21287

				For State Registrar	State of Maryla			nent of H cate of L		Mental Hy	giene Bea. No	2004	10052
	I	Physici	an	1. Decedent's Name (First, Middle, La						2. Date of De Month March	ath		3. Time of Death
		/Medio	cal	Anna C. Foll 4a. Facility Name (If not institution, giv	derauer e street and number)		4b.	City, Town, or	Location of Deatl	-		County of Death	0900 AM
	1	- LAGITIII		Upper Chesapeake		r		Bel Air			ŀ	Harford	
		Funeral Director		212-03-2100	6ex 7. Age (In yr			Inder 1 Year oths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da March	th Year) 26,	9. Birthe Cour 1915 Ma	place (State or Foreign htty) Iryland
		land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town	or Location	1				1	0d. Inside City Limits
		e Man ta-f sh tifled	ctor	Md. Harford		Bel	Air						1 ☐ Yes 2 🕱 No
		death with the Maryland rms 23a or 28a-f show r must be notified at	al Director	10e. Street and Number 1823 Wye Mills	Lane		10	f. Zip Code 2101	.5		10g. Cit	tizen of What Cour	-
	920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Examinat must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	U.S.		Decedent of Hi. specify Cubar es 2 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No to Rican, etc.))-	14. Race - Americ Black, White, Specify:	
0900 Am	Maryland 21215-0036	within 72 ho ene. than "natur he Medical	Be Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)		(Give kind of life. DO No		ition luring most of wol	rking	16b. K	(ind of Business/In	
20%	121	Hygier ther th	S	O 17. Father's Name (First, Middle, Last)	HOI	memake	er	18. Mother's Nar	na (First Middle	Maiden	Own Home	
0	lano	lid be flental l	To Be	Adam Klimczak					Mary	Dziados		, oamamo,	
	fary	2 shot and N ts mai		19a. Informant's Name/Relationship (or Town, State, Zip	Code)
10%		1 and Health tem 27		Mr. Thomas Folder 20a. Method of Disposition				(Name of vor other place	even Val	lleys, P		.7360 ocation - City or To	own, State
28/0	о Ш	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				or other place Cemeter		L-2004		kesville	
3/	Baltimore,	permit. Deportmit. Importa any inju		21. Signature of Funeral Service Licer	1 Dust		22. Nan Kl 1(JCK TOW 050 Yor	s of Facility SON Fune k Rd. To	eral Hom	e. I	nc.	
	ī			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	eath. Do n	not enter the	mode of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	ł	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Res	pir	ator		ilure				Onset and Death
		Examiner			Due to (or as a con-	equence o	$=\mathcal{D}$	unes					Mars
		pe tis	lner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a cons	equence d	The Co						0
F		axecute n and al-tran	Examiner	that initiated events resulting in death) Last	c. Ly lav	eque (cr o	alu of):	re	74 72				years
17	68760	ficate be executed physician and is the burial-transit	edical E	· ·	d. Mrein	nj_	Ava	ct in	fection	h			years
79		- CD	Med	IF FEMALE:	20- 16	J	-		<i>U</i>				0
E TO	O. Box	that the death certifed by the attending detached for use a	by Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of prec 1 Live birth 2 Fe 4 Pregnant at time o	tal death		pic pregnancy or (specify)				23d. Date of delive Month	ory Day Year
MOH	ds, P.	 requires that the bear signed by should be detact 		Part II. Other significant conditions of	contributing to death but not r	esulting in	the underly	ring cause give	n in Part I.			use contribute to th	
hna	Records,	e lav has	Completed							24a. Was auto perfo 1 \(\text{Yes}		prior to con death?	psy findings available mpletion of cause of
A	, Vital	, u	Be	25. Was case referred to medical examiner?					26. Place of Dea			, , , , , , , , , , , , , , , , , , , ,	- IN:
2	of	Physician: r this certific ral director,	5.	1 ☐ Yes 2 No 27. Manper of Death	28a. Date of Injury	ER/Out		DOA Othe	4 Nursing H	lome 5 Resi		6 Other (Specify	y)
7,7	ion	Attending F r death. ector: After by the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	l In	njury M	28c. Injury Work	? ∕es 2 □ No			,	
eran	Division	after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		home, far	rm, street, fa	actory, office		28f. Location (City or To	Street an wn, State	nd Number or Rura e)	l Route Number,
Tolo		To the Hospital or Attending Physician; within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example	nysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, ination and	, death occu d/or investig	urred at the tim ation, in my op	e, date and place inion, death occu	, and due to the irred at the time,	cause(s)) and manner as si d place, and due to	tated. the cause(s)
		To the I within 2. To the I complet	Me	29b. Signature and title of certifier	00			29c. License	number	7770	29d. Da	ite signed (Month,	Day, Year)
	7			Cellia c	3 oun	wo		0-	0018	117	Ma	ich 28	,2004
				30. Name and address of person who	Completed cause of death (II	171	16 A	artor	d Roa	d, Suite	10	5/211	ston MI)
		Sta Regist		31. Date filed (Month, Day, Year) APR 0 1 2004	32. Registrar's Sig	ure	Spor	Kar				2	Day, Year) 7,2004 8 foin MD 1047

		30. N e and address of person who completed a u	so of death (Itam 23a) (Tues	Drint)			
1 × 0 0)	MD	RES-OC		March 28	
To the Hospital within 24 hours a To tha Funaral Completely filled	Medical	(Check only 2 Medical Examiner: On the b			th occurred at the time,		e to the cause(s)
To the Hospital or Attanding Physician: The Within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page		4 Homicide determined 2009. Flated build 2009. Certifier 12 Certifying Physician: To the	ing, etc. (Specify)		City or Tov	wn, State)	
Lor Attanding after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, s	M 1 ☐ Yes 2 ☐	28f. Location (S	Street and Number or R	ural Route Number,
ding Physiclan: h. After this certification of the director, in the director director, in	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ 27. Manner of Death 28a. Date			rsing Home 5 Resid	dence 6 Other (Spe	cify)
vital nec siclan: The law certificate has b lirector, page 2 s	Be Co	25. Was case referred to medical examiner?			1 ☐ Yes of Death (Check only o	2 No 1 ☐ Yes	2 N o
vical necolos, siclan: The law requires t certificate has been signs rector, page 2 should be	Completed	Atrial Fibrillation, Aort	ic Stenosis	Renal		osy prior to death?	utopsy findings available completion of cause of
w requires the been signed should be d	b	10 M. 11 S. 1. 11	1				robably 4 Unknown
The law requires that the death certifica The law requires that the death certifica tite has been signed by the attending ph bage 2 should be detached for use as it	Physician/M	1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to d	own		23e. Did to	obacco use contribute to	the cause of death?
box contificat leath certificat attending phy	ian/Me	in the past 12 months?		□Ectopic pregnancy		23d. Date of de Month	livery Day Year
9 × 6	edical	d					
te be executed ysician and le burial-transit	Examiner	that initiated events	(or as a consequence of):				
	ner	Sequentially list conditions, if any, leading to infiling cause. Enter Underlying Cause (Disease or injury	(or as a consequence or).				
Physician /Medical Examiner		disease or condition resulting in death) a. — Due to	(or as a consequence of):	Infarction			2 days
Physician		23a. Part1. Enter the dispase, or complications that of shock, or heart lattere. List only one cause on a limmediate Cause (Final	I M 1. 1		cardiac or respiratory ar	rrest,	Approximate Interval Between Onset and Death
permit. Departr Imports any inj		21. Sign and of Funda Service Licensee		22. Name and Address of Facility 3900 REISTERST(SON & BROS. PIKESVILLE,	
Page nent o ant: If ury or		1 X Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	State BNAI ISF	RAEL CEMETERY	3/30/2004	BALTIMOR	E, MD
		MARILYN WERTHAMER / DAU	20b. Place of Disp	SUTHERLAND COUP	RT - BALTIMO	ORE, MD 212	
d 2 should be filed within the and Mental Hygiene. 77 Is marked other then traumatic event, If a M.	J.	LEON 19a. Informant's Name/Relationship (Type, Print)	WAXI 19b. Mail	MAN I DA ling Address (Street and Number		er, City or Town, State, .	WALMAN Zip Code)
in y rail of E.E. 1.2. 1.2. 1.2. 2.2. 2.2. 2.2. 2.2.	Be Co	17. Father's Name (First, Middle, Last)		18. Mothe	er's Name (First, Middle,		
within 72 ne. ihan ne	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1)	(Give	e kind of work do ne' during mos DO NDT use retired) EMAKER	t of working	OWN HOME	,
within 72 hours after death with the Maryland with 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Maryland at must be notified at	þ	3 X Widowed 4 □ Divorced If Yes, Gin Year or D	ve lates:	1 ☐ Yes 2 💢 No Specify: edent's Usual Occupation	1	Specify: 16b. Kind of Business	WHITE
iter deat	Funeral Director	11. Marital Status 12. Was Dec Armed Fo	2 🕅 No	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican	gin? (Specify Yes or No n, Puerto Rican, etc.)	- 14. Race - Ame Black, Whit	e, etc.
h with th	ai Dire	10e. Street and Number 2903 TANEY ROAD		10f. Zip Code 2120		10g. Citizen of What Co	U.S.A.
e Maryli Ba-f sho	ctor	MD N/A	BALT	TIMORE			1 D Yes 2 □ No
D.		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation	1001 10	3,1920	10d. Inside City Limits
Funeral Director		5. Social Security Number 6. Sex 1 M 2 T F	7. Age (In yrs. last birthday 75 Yrs.		Min. Date of Birt (Month, Da MAY 13	th 9. Bir y, Year) Co	thplace (State or Foreign buntry)
Examir		4a. Facility Name (If not institution, give street and number 5 ing: Hospital of	saltimore	4b. City, Town, or Location of Baltimore	of Death	4c. County of Dea	n/A
/Medi		LILYON		FRADIN	March	Day Year	+ 410 AM
Physici		Decedent's Name (First, Middle, Last)			2. Date of Dea		3. Time of Death

ORIGINA POLICE

2004

GRIFFIN

BENNIE

		1	For State Registrar	State of Maryland /	Depa Cer	artment of Hetificate of L	ealth and M Death	fental Hyg	giene 2001	10055
			1. Decedent's Name (First, Middle, Last)				2, Date of Dea Month	th Qay Year	3. Time of Death
	Physicia /Medic	_	JEAN GI	ove				03	23 04	1030H M
	Examin	_	4a. Facility Name (If not institution, give			4b. City, Town, or	_		4c. County of Dea	th
			Bayview Medica 5. Social Security Number 6. Se		hirthdayl	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Funeral Director			M 252F 81	Yrs.	Months Days	Hours Min.	April 9	r, Year) C	ountry) onsylvania
			Usual Residence of Decedent					APLIL	, 1)22 16	*
	how		10a. State 10b. County	10c. City, To			1.			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f s	Sc	Maryland Harfor	:a		Churchvil	-те		10g. Citizen of What C	
	with the	Dir.	10e. Street and Number 311 Windsor Cour	-+		10f. Zip Code	21028		USZ	
	eath v	eral	11. Marital Status	12. Was Decedent Ever in U.S.	13. \	Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No-		erican Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ira Marical Examinar must be natitived at other traumatic event, Ira Marical Examinar must be natitived at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	ĺ	fYes, specify Cuba 1 ☐ Yes 2√2 No	n, Mexican, Puerto Specify:	Rican, etc.)	Specify:	vhite
ŏ	2 hor	ted	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occupa	during most of work	ing	16b. Kind of Business	/Industry
21215-0036	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)		Own ho	
2	led wi lygien her th		17. Father's Name (First, Middle, Last)		Н	omemaker	18. Mother's Nam	e (First, Middle,	Maiden Sumame)	ле
Maryland	ntal H ed ot	Be		Koser		=		(u/k)	Beharry	
Z	should nd Me mark matic	ဥ	Charles Harnish 19a. Informant's Name/Relationship (7)		9b. Mailir	ng Address (Street a			r, City or Town, State,	Zip Code)
Ma	nd 2 s lith ar 27 is r trau		Elizabeth G. Ehrh		311	Windsor C	Court, Ch	urchvill	le, Marylan	nd 21028
ē,	s 1 ar f Hea item othe		20a. Method of Disposition	ceme	of Dispo	sition (Name of matory or other plac		Date	20c. Location - City o	r Town, State
Ë	Page nent o int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Hillt	op S	ervice Co	orp. 3/26	/2004	Towson, Ma	aryland
Baltimore,	permit. Pages: Department of It Importent: If ite any injury or of once.		21. Signature of Funeral Service Licen	nas Ranington	Mc	2. Name and Address Comas Fur 17 Cokesh	neral Hom	e, P.A.	don, Maryla	and 21009
			23a. Part 1. Enter the disease, or composhock, or heart failure. List only	lications that caused the death. I	Do not ent	ter the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Proysician		Immediate Cause (Final disease or condition	ASCVD						Onset and Death
4	/Medical		resulting in death)	Due to (or as a consequen	ce of):					
	Examiner		Sequentially list conditions,	b. Due to (or as a consequen	on of):					
	ed	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	Ce Oi).					
	tate be executed oblysician and the burial-transit	Exami	that initiated events resulting in death) Last	c Due to (or as a consequen	ce of):					
8760,	e be e siciar e buria	calE		d						
Ö	tificate g phys as the	ledic	22.							
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deatl 9 ☐ Unknown	ath 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	elivery Day Year
P.0	res that the de signed by the a be detached t	Phy	9 Unknown Part II. Other significant conditions c	potributing to death but not resulting	ng in the u	inderlying cause giv	en in Part I	23e, Did to	obacco use contribute	to the cause of death?
	signer d be d	d by	Part II. Other significant conditions o	Simplify to doubt but not result		g caace g		101	/es 2 □ No 3 □ F	Probably 4 Dinknown
of Vital Records,	w require been sig should b	Completed						24a. Was		autopsy findings available
Re	The law ate has page 2:	E G				•			rmed? h death?	completion of cause of
tal		0	25. Was case referred to medical		1		26. Place of Dea			
Ξ	Physicien: this certifical	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursing H	ome 5 Resid	dence 6 Other (Sp	ecity)
	ding Ph J. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	b. Time o	Wor	k?	28d. Describe h	now injury occurred	
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		. ()		Yes 2 □No	28f Location /	Street and Number or I	Rural Route Number
Division	i E to	Certification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, rarm, st	reet, ractory, office		City or Tox		tural Hosto Hamber,
	To the Hospitel or A within 24 hours after To the Funerel Direction pletely filled in by		29a, Certifier 1 Certifying Ph	ysician: To the best of my knowle	dge, dea	th occurred at the tir	me, date and place	, and due to the	cause(s) and manner	as stated.
	e Hos 24 h e Fur letely	edicai	(Check only 2 Medical Exar	niner: On the basis of examination and manner stated.	and/or in	nvestigation, in my o	pinion, death occu	rred at the time,	date and place, and di	ue to the cause(s)
	To th Within To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Moi	nth, Day, Year)
			DM, MD			DJA	727		3271	1
	0		01	completed cause of death (Item 2	3a) (Type	, Print)		sla m	1 22.0	
	7			201-109 Bach	relycl	Asso de	vicual V	sed M	VXICCI	
	St Regist	ate rar	31. Date filed Month, Jay 1 2004	ar a Signatur	/	Constitution of the				

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** DOROTHY GIBSON MARCH 1:55 A.M 31, 2004 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HARFORD ROCK SPRING VILLAGE ASSISTED LIVING FOREST HILL
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/2/1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☐ xF 216-24-4505 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No HARFORD FOREST HILL Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 COLGATE DRIVE 21050 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify À Specify: 3 XWidowed 4 □ Divorced WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 8TH_GRADE marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked other any injury or other traumatic event page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GREGORY RICHARD RAAB ELIZABETH BAUER 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER R 1703 EFICKHOUSE LANE
20b. Place of Disposition (Name of cometery, crematory or other place) FALLSTON, MD 21047 Date 20c. Location - City or Town, State DONNA MEYER 20a. Method of Disposition 1 € Burial 2 Cremation 3 Removal from State MORELAND MEM. PARK HILLENDALE, MD 4 □ Donation 5 □ Other (Specify) 4/3/2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OBSTRUCTIVE PULMONARY CHRONIC **Physician** ten years /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Linknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛍 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 45519 12- J 2 1 ☐ Yes 2 ¥ No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? LIVING Certification: After 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1355 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE BELAIR MARYLAND Z NORTH d APR 0 32. Registrar's Signature 31. Date filed (Month, Day, State 1 2004 Registrar

ORIGINAL

Brenda Gunthrop Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 20601- State of Maryland / Department of Health and Mental Hygiene Certificate of Death AKG Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 Year **Physician** Gunthrop Brenda March 24, 10:42 A^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Bon Secours Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DT 14 1941 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Days Hours 220365836 62 Yrs. Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD Baltimore 1 ¶Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 717 Druid Park Lake Drive Apt484 21217 238 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: BLACK 3 Widowed 4 □ Divorced Year or Dates: "natursl" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other then Human Services Service Rep ath N/A community 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Department of Health and Mental Important: If item 27 is marked o eny injury or other traumatic evenoce. Pages 1 and 2 should be MORRIS MODRE Bernice Woodland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Dollalass Brompton Rd. Woodlawn MD 21207 6714 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Park Randallstown MD ' 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility CENE FUNERAL SERVICES 21. Signature of Funeral Service License Cu 5151 BALTO NATIONAL DIKE BALTO MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Observed or right that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate by executed and physician a s the burial-t Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Po Month Day Year 5 Other (specify) P.O. the th þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Chronic Alcohol Abuse has been signed to the second 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2□ No 24a. Was an rector, page 2 autopsy performed' 2 □ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one 1 Inpatient Other: Certification: To 1XX es 2 □ No 2 XER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Diractor: ormpletely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

State Registrar

DHMH 17 Rev 1/2001

Medical

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) APR 0

30/Name and address of person who completed cause of death. It in 23a) (Type, Pr. t)

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 25, 2004

			For 1 - State Registrar	State	of Marylan		artment				lental Hyg	^	004	10058
	Physici	an	1. Decedent's Name (First, Middle		-11						2. Date of Deat Month	n Day 26	2004	3. Time of Death 7:15 A.
}	/Medic Examin	al	Edith Virg 4a. Facility Name (If not institution 207 Church	n, give street and n					Location o		March		nty of Death	imore
	Funeral Director		5. Social Security Number 213–28–6167	6. Sex 1 ☐ M 2 ☒ F	7. Age (In yrs. 7		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, May 8,	Year) 1930	9. Birthp Cour Ma	elace (State or Foreign etry) ry1and
	f show	or	Usuel Residence of Decedent 10a. State 10b. County Maryland Ba	ltimore	10c. Cit	y, Town or Lo	cation terst	Own					1	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
	ith the h or 28a-i	Director	10e. Street and Number	TETMOTE		RCIB	10f. Zip				1	0g. Citizen	of What Cour	ntry?
	sath w	erail	207 Church Ro		edent Ever in U	S 13 1	Was Deced	211		iain? (Sn	acify Yes or No-		ted Sta	
920	ours after de al', or item Ever draer	by Funerai	11. Marital Status 1 □ Never Married 2 □ Mar. 3 ☒ Widowed 4 □ Divorced	ied Armed F	orces? 2⊠No ive	1	If Yes, spec		Specify:		ecify Yes or No- Rican, etc.)	E	Black, White, cify: Whi	etc.
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d 2	Hygir Ther nt,	Be Co	17. Father's Name (First, Middle,	Last)			ПОП	emak		er's Name	e (First, Middle, I	Maiden Sun		Jille
/lan	2 should be f and Mental H Is marked of raumatic ave	To B	Clarence Edw	ard Morma	ınn						se Emma			
Mar	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relations Mr. Ralph O. G		r. son						a <i>l R</i> oute Number :erstown		wn, State, Zip 21136	Code)
a)	ges 1 and 2 t of Health If item 27 I or other tra		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 □Removal from	State	Place of Dispo cemetery, crea	natory or of	ther place	1				on - City or To	
Baltimore,	permit. Pages: Department of h Important: If ite any injury or of		*4 ☐ Donation 5 ☐ Other (S		Ca	22	2. Name an	d Addres	s of Facili	itv	necession and an order			cead, MD
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	Physician /Medical		23a. P. rt1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on	ead line.		ced	. ^	-		or respiratory arr	est,		Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions,	b. —	HASC	uence of):								45
8760,	death certificate be executed e attending physician and ad for use as the burial-transit	icai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S	(or as a conseq									
.O. Box 68	death certifi e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregna birth 2 Fete gnant at time of d nown	oldeath 3	Ectopic pro					23d.	Date of delive Month	ery Day Year
<u>α</u>	8 5 6	by	Part II. Other significant conditions Sevene F	ons contributing to	death but not res	ulting in the u		ause give	en in Part	l.	23e. Did to			he cause of death? pably 4 □Unknown
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Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital				Othe			h (Check only or			
on of	ding Phys After this funeral di	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. Date (Mo	Inpatient 2 of Injury onth, Day Year)	28b. Time o Injury		8c. Injury Work	at		ome 5 Feside 28d. Describe h			(v)
		Certification:	3 Suicide 6 Could determ	ined 289. Plac	e of Injury - At h ding, etc. <i>(Specil</i>	ome, farm, str fy)	reet, factory	, office			28f. Location (S City or Town		umber or Rura	al Route Number,
	e Hospital or 24 hours afte e Funeral Dir letely filled in	Medical C	29a. Certifier 1 Certifyii (Check only one) 2 Medicel	ng Physician: To the Exeminer: On the and ma	e best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred vestigation,	at the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the c red at the time, d	ause(s) and late and pla	I manner as s ce, and due t	stated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifie	, No	d			-	number	2	2	-	gned (Month,	
	10		30. Name and address of person	who completed cau	use of death (Iter	n 23a) (Type,	Print)						26/04	1
	Ψ		Jay Stephen Mr	*R6005 9	panters	mier F	21.0	سرس	رن ۱۸	116	hd 2111	7.		
	Sta Registr		Jay Stephen Mr. 31. Date filed (Month, Day, Year)	1 2004	Contrar a Signa	K,	Good	ف	•					

	Physici		Decedent's Name (First, Middle R I	, Last) MON	F.		GETZOV		2. Date of De Month MARCH	28, 2004	Year 1	3. Time of Death 12:40 P M
	/Medic Examin		4a. Facility Name (If not institution					Location of Death	THICH	4c. County		12.40 F
		ulicilie udrate	HOSPICE OF BALT				V.11-4-4-V	TOWSON		E	BALTI	
	Funeral Director		5. Social Security Number 142-24-7339	6. Sex 1 M 2 ☐ F	7. Age (In yrs. 71	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da FEB.21	y, Year) 1933	9. Birthpl Coun	lece (State or Foreign try) NJ
-5	T		Usual Residence of Decedent						1 2 0 . 2 1	,1300		
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	the Maryland r 28e-f show	rect	10 O IN	irwood Cour		LUINE	RVILLE 10f. Zip Code			10g. Citizen of W	/hat Coun	λ
9	death with the ms 23a or 28e Frount be not	Funeral Director	8 BURNWOOD COL	IRT COUL				21093			U	.S.A.
3	after deal or Items : ruther rut	nue	11. Marital Status	Armed Fo		S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No Rican, etc.)	- 14. Race Blac	- Americ k, White, (
980	a o	by	1 ☐ Never Married 2 💢 Marr 3 ☐ Widowed 4 ☐ Divorced	led 1 ☐ Yes If Yes, Gi Year or D	ive X Dates:	1	☐ Yes 20X No	Specify:		Specify	. WH	ITE
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2 2	be filed within stal Hygiene. od other than event.	Be C	17. Father's Name (First, Middle,	Last)	•			18. Mother's Name	(First, Middle,			
2004 ryland	2 should be fi and Mental H is marked ot raumatic ever	70	SAMUEL			GETZ		ELIZAB				COHEN
_ 0			19a. Informant's Name/Relations CONSTANCE GETZ		=	196 Mailin	g Address (Street a	ond Number or Rura	I Route Numbe THFRVII	er, City or Town, IF MD 2	State, Zip 21003	Code)
્તુ નૃ	a a E E		20a. Method of Disposition		20b. P	lace of Dispos	sition (Name of latory or other place		ate	20c. Location -		
March 2 Baltimore,	permit. Pages 1 Department of H Important: If ite eny injury or ott		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecity)	BAL			CEM. 3/30,				WN, MD
Balt	Depart Depart Import eny in		21. Signature of Funeral Service	Joensee XXIII			Name and Addres	301		SON & BF		
2			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death			ERSTOWN I			LE,	Approximate
	Physician		Immediate Cause (Final disease or condition	only and cause on o	each line.	- n	127/2	010				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a contequ	uence of):	7010					proces
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consequ	uence of).						
MVV	and I-transit	Examiner	that initiated events	c								
760,	be executed ician and burial-transit		resulting in death) Last	Due to	(or as a consequ	uence of):						
687	9 % 0	edical		d								
	The law requires that the death certificat tie has been signed by the attending phy page 2 should be detached for use as th	Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	itcome of pregna		Ectopic pregnancy				of delive	
ലാറ P.O. Box	the att	sick	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nant at time of de		Other (specify)			Mor	ith	Day Year
	that the de ed by the a detached t	/ Ph	Part II. Other significant condition	ens contributing to d	leath but not resi	ulting in the un	derlying cause give	n in Part I.	23e. Did t	bacco use contri	ibute to th	e cause of death?
rds	w requires t been signe should be	ed ba	Congestive 1	Jeart	Failur	<u></u>			1 🗆 '	res 2□No	3 🗌 Proba	ably 4 √Unknown
Records,	law re as bee	plet							24a. Was	sy p		osy findings available inpletion of cause of
9 E											eath?	2 □ No
772 Vital	Attending Physicien: r death. ector: After this certifica	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatient	3 DOA Othe	26. Place of Death		30	er (Specify	hospite
S to	ding Phys h. After this funeral di	n: T	27. Manner of Death	28a. Date		28b. Time of Injury	28c. Injury Work	at 2		now injury occurre		7. 2. 3. 1. 0. 0
sion	Attendir death. ctor: Af y the fur	catlo	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	pation			M 1 🗆 Y	res 2 □No				
Division	i or At after o Direct I in by	Certification:	4 Homicide determ	ined 288. Place	e of Injury - At ho ling, etc. <i>(Specif</i> y	me, farm, stre	et, factory, office		City or Tov	Street and Numbe vn, State)	or Or Hurai	l Route Number,
	To the Hospital or Attenc within 24 hours after death To the Funerel Director: completely filled in by the I	Medical C	(Check only one)	g Physician: To the Examiner: On the b	a bast of my kno basis of examinal oner stated.	wiladge, death tion and/or inv	consumed at the time estigation, in my op	e data and place, a inion, death occurre	and due to the ed at the time,	sauso(s) and mar date and place, a	net as sto	ated. the cause(s)
	To the vithin 2 To the comple	Me	29b. Signature and title of certifie		states		29c. License	number		29d. Date signed	(Month, L	Day, Year)
		114	Mana	u m	0		1728	303		worch.	28 2	2004
	20		30. Name and address of person	who completed cau	se of death (Item	23a) (Type, F	Print)	Cr Rel	+11110	(MA) 7	DOIL	
	0		31. Date filed (Month, Day, Year)	32 6	Registrar's Signa	VI 100	TARATC!	31 1200	timors	INVO C	1004	
	Sta	ite	31. Date filed (Month, Day, 16a)	J2. F	negisilal s Sigila	iure .	South	ž .				

ORIGINAL

			1 - For State Registrar AMEND ITEM #9 I	State of Mar	yland / Depa	artment of H	lealth and N	Mental Hygi	_	04	10060
			Decedent's Name (First, Middle, Last)	PER FII GOOU 4	+/ UZ/ U4 Jm			2. Date of Death			3. Time of Death
	Physici		Silvio E. Gallo					March 31	, 2004	Year	1:45 AM M
	/Medio Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	r Location of Death		4c. County		
			3717 Eastman Rd.			Randalls			Baltir		
	Funeral		5. Social Security Number 6. Sex	7. Age (i	n yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpla Count	ace (State or Foreign ^{ry)} PFNNSYLVANL 1and
	Director		188-24-5166 TSJ		/ Z 115.			Mar. 30,	1932	Mary	land
	land ow	Ì	10a. State 10b. County	1	0c. City, Town or Lo	ocation				10	d. Inside City Limits
	Many Iffed	tor	Maryland Baltimore		Randalls	town					1 ☐ Yes 2 ☑ No
	or 28s	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Count	ry?
	23a c	a [3717 Eastman Rd.			21133			Untied		
	tems	nue	Tr. Warran States	Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- America k, White, e	
36	or l	y F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 📆 Yes 2 🗆 No If Yes, Give Year or Dates: Ko	rea	1 ☐ Yes 2 ☑ No	Specify:		Specify:	Whi	te
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28a-1 show the M. direl Examinar must be notified at	Completed by Funeral Director	15. Decedent's Educ		16a Dece	dent's Usual Occupa	ation	1	6b. Kind of Bus		
15	n "ne n "ne	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of world)	king			·
212	d with	E O	12th		Insu	rance Age	nt		Mass Mu	itual	Insurance
b	al Hygid I other vent, I	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, M	aiden Sumame	9)	
ylai	should bund Ment marked umatic o	2	Peter Gallo				Thressa				
Maryland	C1 00 00		19a. Informant's Name/Relationship (Typ			ng Address (Street					Code)
	1 and 1ealith Im 27		Teressa Gallo (W	rife)	371.	7 Eastman	Rd. Rand		MD 21		vn State
Ö	Pages 1 nent of F int: If ite		1 Burial 2 ☐ Cremation 3 ☐ Re	emoval from State		osition (Name of matory or other place			Sykesvi		
Baltimore,	t. Pa rtmen rtant: njury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Euperal Service License 	200		W Mem Parl 2. Name and Addres		104			
Bai	permit. Pages 1 and: Department of Health Important: If item 27 eny injury or other tr		21. Signature of Editional Service License	allen	Βι	ırrier-Qu	een Funer	al Direc	tors, P	.A.	
		- 7	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused th	e death. Do not en	LIZ West (OLC Liber ig, such as cardiac	or respiratory arres	intield st,		Approximate
	erent contract of the contract of		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	. 1	C 11					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to for as a c	consequence of	tarlure	/			~ 1	1 would
	Examiner			Meta	static 1	ung como	PA			~ 3	3-4 months
	_ ~	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a c	consequence of):	0					
	cutec nd ransi	Examiner	Cause (Disease or injury that initiated events c								
760,	ite be executed lysician and he burial-transit		resulting in death) Last	Due to (or as a c	consequence of):						
876	ate b	dlcal	€ d	•							
89 x	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	by Physician/Med	IF FEMALE:	Bc. If yes, outcome of	pregnancy				224 D-14		
Box	attend for us	ian	in the past 12 months?	1 ☐ Live birth 2 { 4 ☐ Pregnant at tin	Fetal death 3	Ectopic pregnancy Other (specify)			Mon	of deliver th	y Day Year
P.O.	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	70 01 00au 1 5 E						
	that the de ned by the a detached f	Y P	Part II. Other significant conditions con	tributing to death but i	not resulting in the u	inderlying cause give	en in Part I.	23e. Did toba	cco use contri	bute to the	e cause of death?
rds	w requires that been signed to should be det	d b						1 ☐ Yes	2 🗆 No	3 Proba	ably 4 □Unknown
00	~ D 0	lete						24a. Was an	24b. W	/ere autop	sy findings available
Re	The law cate has page 2 :	Completed						autopsy perform 1 ☐ Yes 2	ed? de	eath?	pletion of cause of 2□ No
ta	ticien: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Dea	th (Check only one			-
Ž	ing Physicien: n. After this certifica	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 🗆 Inpatient	2 ER/Outpatie	nt 3 DOA Cth	er: 4 🗌 Nursing H	ome 5 Resider	ice 6 □Othe	r (Specify))
0	ding Phys n. After this funeral dii	Ľ.	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	28b. Time o	f 28c. Injun Worl	y at k?	28d. Describe how	v injury occurre	ed	
<u>.</u>	Attending ir death. actor: After by the fune	atlc	2 Accident investigation				Yes 2 □ No				
Division of Vital Records,	or Att ter de iract	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (At home, farm, st (Specify) 	reet, factory, office		28f. Location (Stre City or Town,		or or Rural	Route Number,
	urs al		**************************************	lata a Tariba basa d							
	To the Hospital or Attendii within 24 hours after death. To tha Funerel Diractor: A completely filled in by the fu	edical		ician: To the best of a ler: On the basis of ex and manner state	camination and/or in						
	o the ithin 3 o tha	Mec	29b. Signature and title of certifier	and manner state	· · · · · · · · · · · · · · · · · · ·	29c. Licens	e number	29	d. Date signed	(Month, E	Day, Year)
	F≩Fŏ		N. 0 /1/2	ver VIO		D	1658	+ -	Moul	131	2004
	00		30. Name and address of person who co	mpleted cause of dear	th (Item 23a) (Type.						
	20		Paul Chans 1	10 560	Loel,	Rievan B	look Ste	107 Ba	An MAN	in No	10 21239
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's	Signature			/		1	
	Regist	rar	APR 0 1	2004	water of	Coastis					

		1 - For State Registrar	tate of Maryland	d / Depa <i>Cer</i>	rtment of H	lealth and Death		iene 0	04 10061	
Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day	Year 1/28 A-M	
/Med Exami		Marguerita 4a. Facility Name (If not institution, give stree SINAI	at and number)			r Location of Deat		4c. County		_
Funera Director	_	5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	Birthplace (State or Foreign Country) NM	1
yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation	-			10d. Inside City Limits	
Ba-f st	ector	MD NA	Bai	ltimo				0- 00	1 ▼Yes 2 No	
IOFC, INTERVIETING ZIZIO-UOSO ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, to Maxical Examiner must be notified at	by Funeral Director	1 Never Married 2 Married	Ints Ave Was Decedent Ever in U.S Armed Forces? I Yes 27 No I Yes, Give Yes, Give Year or Dates:	ì		215 lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Rac	What Country? S.A. De - American Indian, ck, White, etc. S. Black	_
in 72 hour	Completed b	15. Decedent's Education (Specify only highest grade co	on mpleted)	(Give I	ent's Usual Occup kind of work done OO NOT use retired	durina most of wo	rking	16b. Kind of Bi	usiness/Industry	_
A I A I A I A I A I A I A I A I A I A I	Com	12th grade n	College (1-4or 5+)	Веа	auticia				hop	_
yiand outd be filt Mental Hy arked oth atic even	To Be	17. Father's Name (First, Middle, Last)	Į	Unkno			me (First, Middle, i		Unknow	n
IMOICE, MAIN Pages 1 and 2 sh nent of Health and ant: If item 27 is m		19a. Informant's Name/Relationship (Type, Wilbert Thompson— 20a. Method of Disposition 1 Burial 2 Cremation 3 Remo	Friend 20b. Pl	5207	- 1220 mai	Height	S AVE,	Baltin	State, Zip Code) More Md 2121. City or Town, State	5.
Datumore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livensde	Gar	22 M a	Name and Addre	ss of Facility H West		- 51	s Mills, Md	
		23a. Part 1. Enter the disease, vr complicati shock, or heart failure. It is only one co	ons that are and the death		er the mode of dyin	ng, such as cardia			Md 21215 Approximate Interval Between	
Physician /Medical Examine	ı	Immediate Cause (Final disease or condition resulting in death)		eace of):	al I	nfar	cTion		Onset and Death	1
ate be executed shysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ							
death certific	hysician/Med	in the past 12 months?	If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 🗌	Ectopic pregnancy Other (specify)	1			te of delivery nnth Day Year	
w requires that the been signed by the should be detached.	by P	Part II. Other significant conditions contrib	uting to death but not resu	ulting in the un	derlying cause giv	en in Part I.		oacco use cont es 2 🗆 No	tribute to the cause of death?	
The lay ate has page 2	Completed						24a. Was a autops perforr	ned?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
Or VICAL MC Physician: The I rithis certificate ha	Be	25. Was case referred to medical examiner?	iital:	^	Oth	er	ath (Check only on			
_ > 0	on: To	27. Manner of Death 2	1 Inpatient 2 (2) 18a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of	28c. Injur	y at	dome 5 Reside			
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ertification	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At ho building, etc. (Specify	Injury ome, farm, stre	M 1 🗆	Yes 2 □ No	28f. Location (St City or Town	reet and Numb	per or Rural Route Number,	
Hospital 24 hours a 5 Funeral t etely filled i	edical Ce		an: To the best of my known On the basis of examinat and manner stated.							
To the within To the	Me	29b. Signature and title of certifier	Physic	iAN	29c. Licens				d (Month, Day, Year) L 27, 2004	
1		30 Name and address of person who comp	leted cause of death (Item	23a) (Type, I	Print)	Belve	dere f	Ive B.	L 27,2004 1 Hmore, mp	7
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture	& don	V 1 =				

DHMH 17 Rev 1/2001

Known as: Marguerite Marie

Certificate of Death Incompare Name (First, Molecule, Laste) MARCARET A. HEREIT MAR				. For	State of Maryland				Mental Hy	giene	
TOTAL DEPTIMENT OF THE PROPERTY OF THE STATE				1 _ State		Cei	rtificate of	Death		Reg. No. 200	4 10062
Defended of the property of th		Physici	an						Month	Day Yea	
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Social Social Principles So		Examir	er								
December		Euporal	•			ast birthday)	If Under 1 Yea	r If Under 24 Hrs.	8. Date of Bir		
10.5 State 10.6 Courty 10.5 Courty 1				004-20-3043	M 26 F 69	Yrs.	Months Day:	s Hours Min.		, 1934 WEI	BSTER, NY
ROBERT A. ABEL South Comments State Sta		yland Now			10c. City	, Town or Lo	cation	_			10d. Inside City Limits
ROBERT A. ABEL South Comments State Sta		Mar.	ctor	MD PRINCE GEO	ORGES LAU	REL					1 X Yes 2 ☐ No
ROBERT A. ABEL South Comments State Sta		or 28	Dire							10g. Citizen of What 0	Country?
ROBERT A. ABEL South Comments State Sta		ath w	rail			- 1.0					
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ROBERT A. ABEL South Comments State Sta	99	ours at	by		If Yes, Give		1 ☐ Yes 2 🔀 No	Specify:		Specify:	HITE
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22. Name and address of Facility FLECK FUNERAL HOME _ INC. 7601 SANDY SPRING RD. LAUREL, MD 20707 22. Name and address of academy FLECK FUNERAL HOME _ INC. 7601 SANDY SPRING RD. LAUREL, MD 20707 23. Signature Sufficient Conditions, and address of academy FLECK FUNERAL HOME _ INC. 7601 SANDY SPRING RD. LAUREL, MD 20707 25. Name and address of academy functions and caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, such as cardiac or respiratory arrest, functions of the cause of	an	Md be Mental Kad c	o B	ROBERT A. ABEL				MAY	JONES		
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Physician / Medical Examiner Part Concept Concept	Ba	Department		- Lewa Sero	1)						
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29a. Certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29b. Signature and due to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier (29c. License number D43237 MARCH 23, 2004) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL ARMSTRONG, M.D. 14201 LAUREL PARK DR. #102 LAUREL, MD 20707	E E	The la	mo						perfo	med? death?	
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					32. Registrar's Signati						

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RJ			Please 1 1 - For Amend & Unpered It Registrar	State of Mary em #1,23a,27	and / Depa er me (3) <i>Cei</i>	ortment of tificate o	Health and the second s	and M	ental Hy	/giene Reg. No. 1	2001	+ 10063
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Do Month	Day	Year	h.a
	/Medic	al	DARRELL MARTIN 4a. Fecility Name (If not institution, give s			4b. City, Towr	or Location	of Death	March		2004 County of Dea	0335 P. M
	Examin	ier	2509 Liberty Heig			_	Ltimore					
	Funeral Director		5. Sociat Security Number 6. Sex 212-84-6392		yrs. last birthday) Yrs.	tf Under 1 Ye Months Day	ar If Under		8. Date of Bi (Month, D MAY 2	rth ay, Year) 7, 19		irthplace (State or Foreign Country) MD
	faryland show	ō	Usual Residence of Decedent 10a. State 10b. County MD N/A	10c	. City, Town or Lo							10d. Inside City Limits 1 Yes 2 □ No
	the h	rect	MD N/A 10e. Street and Number		BALTIMO	10f. Zip Code	9		1	10g. Citiz	ten of What C	
	h with	a D	2509 LIBERTY HEIG	HTS AVENUE		212	215				USA	
	ems ?	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?		Was Decedent of f Yes, specify C	of Hispanic Ori	igin? (Spe	cify Yes or N	0- 1	4. Race - Am Black, Wh	rerican Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is merked other than "natural", or Items 23e or 28e-f show or other traumatic event, the Madical Extrini	d by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1□Yes 2□N						LACK
5	"natu	ete	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Oct kind of work doi DO NOT use ret	ne during mos	t of worki	n <i>g</i>	16b. Kin	d of Busines	s/industry
72	withir riene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		H MANAG				M	ERCANT	ILE BANK
	al Hygie I other vent, II	Bec	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle	, Maiden S	Sumame)	
Maryland	2 should be i and Mental I is marked of aumatic eve	P P	RICHARD HARRIS						A ROWS			
Mar	d 2 sh h and 7 ts m traum		19a. Informant's Name/Relationship (Typ	•		ng Address (Stre						
	tom 27 tem 27 other tr		RICHARD HARRIS/FAT 20a. Method of Disposition		b. Place of Dispo	WOLCOT sition (Name of			SALT IMC		MARYLA pation - City o	ND 21216 r Town, State
OE	Pages nent of int: If it ury or o		1 5 Burial 2 □ Cremation 3 □ Re 1 4 □ Donation 5 □ Other (Specify)	1 -	comotory, cren XING MEM	natory or other p		4-1-	2004	ВΔ	T TTMOR	E, MARYLAND
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funerat Service License									NS F.H., INC.
_	20 E 2 9		James 9	· mor	con 1	701 – 31 I	LAURENS	ST.	BALT	IMORE	, MARY	LAND 21217
			23a. Part / Enter the disease, or complice shock, or heart failure. List only on	cations that caused the decause on each line.	death. Do not ent	er the mode of o	fying, such as	cardiac o	r respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Atherosclero		vascular	Disease					
	Examiner		Sequentially list conditions	,	304401100 017.							
13	P #	Iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a con	saquenda uf):							
	axecuted and al-transit	xamin	Cause (Disease or injury that initiated events resulting in death) Last	. Due to (or as a con	sequence of):							
, 90	0 5 5	ш		200 (0) (0. 00 2 00)	304301100 01).							
68760	ificate g phys	edic										
.O. Box	that the death certificate be e ed by the attending physicier detached for use as the buri.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pre 1 Live birth 2 f 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnal Other (specify)				2:	3d. Date of de Month	elivery Day Year
۵.	res that the igned by be detact	by Ph	Part II. Other significant conditions con	tributing to death but not	resulting in the ur	nderlying cause	given in Part I.		23e. Did	tobacco us	e contribute t	o the cause of death?
Records,	The law requires that the tee has been signed by this page 2 should be detache								10	Yes 2 1 ⊆	3∏ P	robably 4 Unknown
ecc	e law re has be je 2 sho	Completed							24a. Was		24b. Were a	utopsy findings available completion of cause of
<u> </u>		Con							1 Yes	ormed? 2 ☐ No	death?	
Division of Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	- Cana		Othor		(Check only	120-71		
o	g Phys er this eral di	-	1 X Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatien 28b. Time of	28c. In	jury at	-	ne 5X Resi 8d. Describe			ecify)
ion	Attending I r death. ector: After by the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) tnjury		Vork? □Yes 2□I	No				
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	Hospital or 24 hours after Funeral Cir tely filled in		00-0-47 45-0-41	1.1								
		edical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 1 ☐ Certifying Phys 2 ☑ Medical Examin	ician: To the best of my ler: On the basis of exan and manner stated.	knowledge, death nination and/or inv	occurred at the restigation, in m	time, date an y opinion, dea	id place, a th occurre	nd due to the d at the time,	date and p	and manner a place, and du	s stated. e to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certification	11.			nse number			29d. Date	signed (Mon)	th Day Year) 2004
A	W.		Mullinte me	Youll	(MV)		ME			PILLUL		2004
00			SC Name and address of person who con	mpierad sauce of death	llam Lau, ()ee,	111 Pe	enn Str	eet.	Baltin	ore.	Marv]	and 21201
0	-60	to	31. Date filed (Month, Day, Year)	32. Registrar's S		,						
	Sta Registr		APR 0 1 2004	Serve	19	back	/					

			1 - For State Registrar		of Maryland		artment rtificate					jiene •g. No. 2 () n L	LAASI
	Physici	an	1. Decedent's Name (First, Middle	, Last)	11-0						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution	cive street and au	mbar)		4h City	Town or	Location of	of Dooth	3	29	04	Ties pm.
	Examin	er	Bellinore Rehabit	_		he			21 BYR			4c. Count	ny of Death N/	A
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la		If Under	1 Year	If Under	24 Hrs.	8. Date of Birth	Vocel		place (State or Foreign
	Director		220-20-8669	1		76 Yrs.	Months	Days	Hours	Min.	(Month, Day Jan, 10	1928		vland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						1	Od. Inside City Limits
	Maryl f •hc	tor	Maryland	N/A				Balt	imore	е				1XXYes 2 □ No
	r 28a	Funeral Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Cour	ntry?
	th wit	alD	4330 Newport	Avenue					2123	11			USA	
	er dea	nnei	11. Marital Status	Armed Fo		5. 13.	Was Deced If Yes, spec	ent of His	spanic Orig	gin? (Spe n, Puerto	city Yes or No- Rican, etc.)		ce - Americ	
36	irs aft	by F	1 Never Married 2 Marn ★☑ Widowed 4 Divorced	BVoc Gi	2 □ No ve lates:1946-4	47	1 ☐ Yes 2	XXVo	Specify:			Speci	fy: W	hite
Š	72 hours after death with the Manyland Insturet; or tleme 23a or 28a-f ehow digal Examinar must be mylified at	Completed by	15. Decedent	's Education	1210	16a. Dece	dent's Usua	Occupa	tion			16b. Kind of E	Business/In	dustry
21	within 7 iene. 'then "n	nple	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of wor DO NOT us	e retired)	uring most	t of worki	ng			
12	e filed within al Hygiene. I other then '		8 17. Father's Name (First, Middle, I	antl		Dr	iver		10.11.15	4. 11	(5) 14:14:	Truc		
Maryland 21215-0036	d be fi	o Be	John Henry Hep								e (First, Middle, I e Theres			
Z,	should be ind Mental marked o	스	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailie	ng Address	(Street a	nd Numbe	or Or Rura	I Route Number	City or Town	, State, Zip	(Code)
×	and 2 Balth a n 27 le		Blanche Tragese	r Com	panion		Newpo				Baltimor			
ore	es 1 an of Heal f item 2 r other		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation	3 Pamoval from	State C6	ace of Dispo	natory or ot	her place)			20c. Location	-	
Ē	ment of tant: If it jury or o		' 4 ☐ Donation 5 ☐ Other (Sp	ecify)	Ga:	rdens			i-	4/2/2				Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, its Medical Examinar must be invitined at 20c.		21. Signature of Funeral Service L	aprilie	_	2 E	Name and Surgee 1631 F	Address -Hen alls	s of Facility SS-Se Road	eitz 1 Ba	Funeral altimore	Home, Mary	Inc. land	21211
			23a. Part 1. Enter the disease, or shock, or heart tallure. List of	only offe cause on e	each line.	. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
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ord	w requir been si should	ted					_				1 🗆 Ye	s 2 😿 No	3 Prob	ably 4 Unknown
Records,	e law has b	Completed									24a. Was ar autops	y	prior to con	psy findings available npletion of cause of
	ician: The certificate rector, pag										perform 1 ☐ Yes 2		death? 1 🗌 Yes	2 No
Vital	Physician: The rather this certificate harrel director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatrent 2 🗆 E	D/Outpation	a 🗆 🗠	Other			(Check only on			
o	g Phys er this eral di	H .	27. Manner of Death	28a. Date		P/Outpatien 28b. Time of		c. Injury	at at		ne 5 🗌 Reside 28d. Describe ho			/)
ion	ttending death. stor: Aft the fun	atio	1 Matural 5 ☐ Pending investig.	ation	m, Day rear)	Injury	М	Work′ 1 □ Y	/ es 2 □ N	No				
Division of	or Atterde	Certification:	3 Suicide 6 Could n 4 Homicide determine	and 200. Place	of Injury - At hor	ne, farm, str	eet, factory,	office		2	28f. Location (Str. City or Town	eet and Numl , State)	er or Rura	l Route Number,
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	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director; Atter completely filled in by the funer	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the examiner: On the band man	best of my know asis of examination ner stated.	rledge, death on and/or inv	occurred a restigation,	t the time in my opi	e, date and nion, deat	d place, a h occurre	and due to the ca ad at the time, da	use(s) and ma ite and place,	anner as st and due to	ated. the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier		- 0	\	- 1	License				d. Date signe	d (Month, I	Day, Year)
			1 John	<u> </u>	ent) M.T)	34	359	(0)	110)	3 29	04	
	16		30. Name and address of person v			179			-		0.60	9		
	\	*	31. Date filed (Month, Day, Year)	3900 L	egistrar's Signate	re 15,	ou leve	Ind,	Bal	time	re, Mo	ryland	121	2/8
	Sta Registr		APR 0 1 200	/	- and		suk	Buch				J		
			HER A T Cill	7										

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3 Year **Physician** JORDAN SPENSER M. 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner (tus 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1□M 2□F 75 South Carolina Yrs. Director 214 26 4874 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ans. If item 27 is marked other than "natural", or Itema 23e or 28a-1 show ans. If item 27 is marked other than "natural", or Itema 23e or 28a-1 show any or other traumatic event, Ite Madical Exteringer must be notilitied at ury or other traumatic event, Ite Madical BALTIMORE Yes 2 No MD. N/A Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21215 2501 VIOLET AVENUE U.S. OF A APT 409N Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Giv Year or Dates: 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No 3 Widowed 4 Divorced δ 16a. Decedent's Usual Occupation (Give kind of work done during TABLABT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working LABORER STEEL PLANT Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WALTER JORDAN (DECEASED) MACEY JORDAN (DECEASED) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit Pages 1 and 2 s Department of Health ar Important: If itam 27 is any injury or other trau once. GLADYS BECKWITH (FRIEND) 2501 VIOLET AVENUE APT. 409N BALTO.,MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State MT. ZION CEMETERY 4/5/04 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) LANSDOWNE . MARYLAND GWYNN: 21. Signature of Fur rai Service License 22. Name and Address of Facility
LEWIS T. GWYNN FUNERAL HOME 21215-6393 23a. Part1. Enter the disease, or complications that raused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. BALTO . Ap ximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Vasc 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 2 No 1 Yes 1 TYes To the Hoppial or Attending Physician: within 24 hobys after death.
To the Funaral Director: After this certifica 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0056 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mason MD K-Tonya 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MARCH 30 201014 MILDRED RUTH JOHNSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days **Funeral** Months Hours Min 1 □ M 2 □ F 214-20-9933 Director 78 7/8/1925 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral', or items 23a or 28a-f shov Examinations Demonstried at 1 Yes 2 No BALTIMORE TOWSON Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 306 OAK LANE COURT USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give : I and 2 should be filed within 72 hours after Health and Mental Hygiene. tem 27 is marked other than "natural", or ite other treumatic event, it is Medical Examina. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ 3 Widowed 4 Divorced WHITE Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HOWARD M. LYNCH EDNA M. BURKINS ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 306 OAK LANE COURT JAMES JOHNSON HUSBAND TOWSON. MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 = 6 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4/3/2004 MORELAND MEM. PARK HILLENDALE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. lather 8521 LOCH HAVEN BLVD. TOWSON, MD Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RIGHT LUNG CONSOLIDATION disease or condition resulting in death) HOURS /Medical Due to (or as a consequence of): Examiner S- uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physiclan/Medical as the attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Status Post Left Pneumonectomy for Lung Carcinoma 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2 ☐ No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural M 1 ☐ Yes 2 ☐ No 2 Accident d in by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier D 0060495 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FAN, M.D., 7601 OSLER DRIVE TOWSON. MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

2004

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Registrar

State

31. Date filed (Month, Day, Year)

APR 01

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month Dey Physician Donald F. Kreiner March 28,2004 /Medical 7:40 AM 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Westminister Carroll Co. Westminister Nursing & Rehab. Ctr. If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ XM 2 □ F May 14,1927 Director 215-22-3376 76 Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martai Hygiene. Important: if item 27 ie marked other than "net---" 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Finksburg Maryland Carroll Co. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21048 United States 3368 Old Gamber Road Funeral Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ty⊠Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 → Merried 1 Tes 2€No Specify: Specify: þ 3 Widowed 4 Divorced White 1944-49 Be Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Years Meatcutter Food Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Alice Dora Earle John Edward Kreiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 3368 Old Gamber Road Finksburg, Maryland 21048 Mrs. Eleanor Kreiner / Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) Y□ Burial 2 □ Cremation 3 □ Removal from State 3/31/2004 Holly Hill Mem. Gdns. Middle River, Marylan 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foreral Service Licensee 22. Name and Address of Fecility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Medical Certification: To Be Completed by Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the a completaly filled in by the funeral director, page 2 should be datached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 AYes 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 11 Yes 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Menner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigetion 1 Tyes 2 No 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Rd Westminster, MD 21157 John W. ton 32. Registrer's Signature 31. Date filed (Month, Day, Year) APR 0 1 2004 Registrar

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State of Maryland / Department of Health and Mental Hygiene	U O) (
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			State of Marylan State of Marylan Registrer		artment of Health and ertificate of Death	Mental Hygien Reg. N		10070
	Physicia	an	1. Decedent's Name (First, Middle, Last) JAMES LOGAN				ay Year	3. Time of Death
k.	/Medic Examin		4a. Fecility Neme (If not institution, give street and number) KERNAN HosfitAL		4b. City, Town, or Location of Deal	E 4	c. County of Deat	
	Funeral Director		5. Social Security Number 216-26-7330 6. Sex 1 9M 2 F 7. Age (In yrs.) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Dey, Year		thplace (Stete or Foreign buntry) VK
	Maryland e-f show	tor	10a. State 10b. County 10c. Cit	y, Town or L				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the	al Direc	10e. Street and Number 3201 WALBROCK AVE		10f. Zip Code 21216	10g. C	US A	ountry?
980	be filed within 72 hours after deeth with the Maryland that Hygiene. ad other than "natural", or items 23a or 28e-f show event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Mamed 2 □ Married 3 █ Widowed 4 □ Divorced 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ▼ No If Yes Give Year or Dates:	.S. 13.	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Bleck, Whit Specify: B	e, etc.
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	s 1 and of Health item 27 other t		MATTLE GIBSON 20a. Method of Disposition 20b. F		o CARIBON ST. MIT position (Name of ematory or other place)		Location - City or	CO727 Town, State
Baltimore,	Page nent c ant: K arry or		*4 Donation 5 Other (Specify)	DAR H	IL 04-6	05.04 PIK		, MO
Bal	permit. Departr Importa any inju		21. Signature of Funeral Service Lice (Sye)	Ž 5	AUGHN C- GREENE F	E, BAUTO. 1	RVICE no 21229	
			23a. Pert1. Ent at the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final			c or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death) Due to (or as a consequence)	uence of):	E~ Be L 05			1 minute
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	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq	uanca of):				18 2 2 ys
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Box	ath certif attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of pregnat 1 □ Livre birth 2 □ Feta 4 □ Pregnant at time of degree of the pre	Ideath 3	□Ectopic pregnancy		23d. Date of del Month	ivery Day Year
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Vital	ysicien s certifi director	To Be	25. Was case referred to medical exampler? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatie		ath (Check only one) Home 5 Residence	6 ☐Other (Spe	cify)
on of	ding After fune	tion: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time Injury		28d. Describe how inju		
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	5		30. Name and address of person who completed cause of death (Iter	n 23a) (Type ERNA	Print) N DRIVE BAL	TIMORE	MD.	21207
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	/Medic Examin		4a. Fecility Name (If not institution,				4b. City, Town, or	Location of Death			County of De	
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	Funeral				e (In yrs. last bi	irthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. B	Sirthplace (State or Foreign
c	Director		219-05-9998	1 □ M 21X1 F	83	Yrs.	Months Days	Hours Min.	March	26 , 1		Country) aryland
	ס		Usual Residence of Decedent		· · · · · · · · · · · · · · · · · · ·					•		
	nylan show		10a. State 10b. County		10c. City, Tov	vn or Lo	cation					10d. Inside City Limits
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36	be filed within 72 hours after death with the Maryland all Hygiene. All Hygiene do they than "neturel", or items 23a or 28a-f show other than "neturel", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Amed Forces? 1 Yes 251 If Yes, Give Year or Dates:			Vas Decedent of His Yes, specify Cubar ☐ Yes 2 \ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.))-	14. Race - An Black, Wh Specify:	merican Indian, nite, etc. White
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9	m 0		1 ☑ Burial 2 ☐ Cremation : 1 ☐ Donation 🏚 ☐ Other (Sp.		4		natory or other place Mem。Gdns	· I	004	Be '	1 Air.	Maryland
Baltimore,	permit. Page Department of Important: If any injury of once.		21. Signal, re of Foneral Society		- 111	-		1				
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	Physician		shock, or heart failure. List o Immediate Cause (Final	nly one cause on sach III	4-110	.,	PRIEL	100 1106	2			Interval Between Onset and Death
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C. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)			2	3d. Date of d Month	elivery Day Year
<u>ı</u>	that the by detact	P.	Part II. Other significant condition	is contributing to death b	ut not resulting i	in the ur	deriving cause give	n in Part I.	23e. Did t	obacco u	se contribute	to the cause of death?
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5	telon rsaft al Dii	Certification;										
	To the Hospitel or Attending Physicien: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 11 Certifying (Check only one) 2 Medicel E	Physicien: To the best exeminer: On the basis of and manner sta	f examination ar	e, death nd/or inv	occurred at the time estigation, in my opi	e, date and place, nion, deeth occur	and due to the red at the time,	cause(s) date and	and manner a place, and du	as stated. ue to the cause(s)
	To the I within 2 To the I complet	M	29b. Signature and title of certifier	1 - 51	or 1	40	29c. License			29d. Date	signed (Mor	nth, Døy, Year)
	2		30. Name and address of person w	no completed cause of d	leath (Item 23a)	(Type, I	Print)	200	A	7	-10	7 - 222
)		Janinger 1	· Jula	2 M	all	Cer F	16a	/hyte	alk	MI	2/222
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	1						
DHM	Registr		APP 0 1 2004	Beneva		10	alst				· · · · · · · · · · · · · · · · · · ·	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per Dr., G830,04/01/04dip Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 12:20 PMM 21, 2004 Lawrence Harwood Loats Mar. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2632 Old Taneytown Rd. Westminster Carrol1 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1☑M 2□F 81 Nov 4, 1922 Director 219-07-9258 Maryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Modical Examinar must be notified at 1 ☐ Yes 2 No Susex Selbyville Delaware 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Pintail Dr. 19975 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No WWII If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: ð 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Metropolitan Life Ins. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert C. Loats Beatrice Bertha Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at Important: If Item 27 is eny injury or other trax gncs. Mary L. Loats (Wife) 15 Pintail Dr. Selbyville, DE 19975 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Mar 24, 2004 Hampstead, MD 21. Signature of Funeral Service Lig 22. Name and Address of Facility Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield 21784 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition **Physician** 60 Inf CVIG resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) use as the burial-tran Due to (or as a consequence of). attending physician Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed 2 No 1 ☐ Yes or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Step Son examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home → Home ence 6 ☐ Other (Specify) 1 Tyes 2 No Home Certification: To filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death. Director: Af 1 ☐ Yes 2 ☐ No М 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral L Hospital 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only Pe d 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cate Drive Resterbur Businell 114 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 0 1 2004

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 Pegistrar Registrar Registra 10073 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MARCH 27, 2004 1:25 A M LIPSKER IRVING /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESANT & NURSING HOME BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/16/1914 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Days Months Hours 89 NEW YORK 113-03-0419 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at Yes 2 No N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 7015 PARK HEIGHTS AVE. APT B-1 21215 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2**X** No Specify: WHITE Specify: 3 ₩ Widowed 4 Divorced Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting than Elementary/Secondary (0-12) College (1-4or 5+) 12 ACCOUNTANT **ACCOUNTANT** Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: If item 27 Is marked other tt jury or other traumatic event, Us. 18. Mother's Name (First, Middle, Maiden Sumame) 17, Father's Name (First, Middle, Last) Be FEIN LIPSKER ROSE JULIUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANICE FELDMAN/DAUGTHER 1 OLD PLANTATION WAY PIKESVILLE, MD 21208 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot **NEW MONTEFIORE** 3/30/2004 PINELAWN, NEW YORK * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signet ine of Funeral Space License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Thrombosis **Physician** EREBRAL /Medical Examiner Sequentially list conditions, if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) sician Box 68760 Physician/Medical attending phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: Certification: To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No death. investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAROLD BOB, 7220 PARK HEIGHTS AVE. M.D. BALTIMORE, MD 31. Date filed (Month, Day, Year) APR 0 1 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 10074 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) John 5:45 Am **Physician** Lehner III Α. MARCH 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8305 Berkwood Ct. Baltimore ROSEDALE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 11/15/1941 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 62 1 XM 2 ☐ F 219 36 1026 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be rediffed at Baltimore ROSEDALE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 USA 8305 Berkwood Ct. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes **¾X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 Is markad other than "n Elementary/Secondary (0-12) College (1-4or 5+) Bond Distributors Route Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o John A. Lehner Jr. Regina Stuprich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8305 Berkwood Ct. ROSEDALE, MD. 21237 Anne L. Lehner Wife 20c. Location - City or Town, State Raspeburg MD 21206 20b. Place of Disposition (Name of Gardens Of Falln Date 20a. Method of Disposition 4/1/2004 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale Maryland 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): 3 years resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has ector, page 2 autopsy performed 2 🗆 No 1 ☐ Yes 20 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ₽ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of confifier 3/30/04 D004-2593 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ASHRAF BADROS 22 South Greve St. Univ. of Mayland Balt, MD21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 = For State Registrar	State of Marylan		nt of Health and I	Mental Hygie		10075
			Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		ALBERT			MILLER	March	31 2004	1 1240 AM
	Examin		4a. Facility Name (If not institution, give	0011.	1110	y, Town, or Location of Deati	0:1	4c. County of Deat	h
			5. Social Security Number 6. Se	X 7. Age (In yrs.		altimore for 1 Year If Under 24 Hrs.	8. Date of Birth	/V /	hplace (State or Foreign
н	Funeral Director			QM 20F 79	Yrs. Month		8. Date of Birth (Month, Day, Ye	925 R	laryland
£x.			Usual Residence of Decedent				5411.111	700	
	nylan show		10a. State 10b. County	D	ty, Town or Location	11			10d. Inside City Limits 1 XYes 2 ☐ No
	8a-f	Director		oe B	arlons	Ville	140	011111111111111111111111111111111111111	
	with the	ä	10e. Street and Number	DI	10f. 4	Zip Code	10g.	Citizen of What Co	antry?
	eath of 23	Funerai	13 2 VAIOI	12. Was Decedent Ever in U	.S. 13. Was Dec	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Ame	rican Indian,
(0	r iten	F.	1 Never Married 2 Married	Armed Forces? 1 (X)Yes 2 ☐ No			o Rican, etc.)	Black, White	e, etc.
036	rel', o	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 Ll Yes	2 No Specify:		Specify: W	nte
21215-0036	within 72 hours atter death with the Maryland ene. than "naturel", or iteme 23s or 28s-f ehow ha Madical Examinar must be rediffied at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's Us (Give kind of	work done during most of wor	king 16b	. Kind of Business/	Industry
121	Mithin Bane.	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	FY B C	tile Rocci	liter	Privato	Firm
	filed with Hygiene. other than	e Co	17. Father's Name (First, Middle, Last)		- ACCU	18. Mother's Nar	ne (First, Middle, Maid	den Sumame)	
an	Mental Mental Marked o	To B	Frederick	Miller		Mary	Rach	ael H	orton
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Ifem 27 is marked other than "naturel", or iteme 23s or 28s-1 show other traumatic event. The Madical Examinar must be ruitilised at	Γ.	19a. Informant's Name/Relationship (7	ype, Print) [niece	19b. Mailing Addre	ss (Street and Number or Au	ral Route Number, Ci	ity or Town, State, 2	(ip Code) 21084
	1 and 2 Health		Ms. Kobin K.	Deckert	1815 In	out tarn		arrettsv	ille, Md.
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	Place of Disposition (Accemetery, crematory of	r other place)	2004	. Location - City or	Iown, State
Ë			4 □ Donation 5 □ Other (Specify		The second second second second second	rematory and Address of Eculity	12004 5	trouds	burg, rai
Bal	permit. Departr Importe any inju		21. Signature of Funeral Service Licen:	Y WALLA	1 /Josep	oh Likuss	Funera	1 Home	17.11
	. 6		23a. Part J. Enter the diffease, or comp shook, or heart failure. List only of	ilications that caused the dear	th. Do not enter the m	ode of dying, such as cardia	or respiratory arrest,	Di Ma. Z	Approximate Interval Between
	Physician		Immediate Cause (Final						Onset and Death
	/Medical		disease or condition resulting in death)	a. SEPS (S Due to (or as a consec	quence of);				1 day
	Examiner		Sequentially list conditions.		PERITON	ITIS			4 days
	pa is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a consec					
	xecut and al-tran	хап	that initiated events resulting in death) Last	c. DuoDE	uence of):	ER			unknown
68760	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	calE		d					
89	g phy as the	ed	6						
Вох	leath certific attending pl	N/C	23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		pregnancy		23d. Date of del	,
	the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of of 9☐Unknown				Month	Day Year
P.O.	that the de ed by the detached		Part II. Other significant conditions of	ontributing to death but not re-	sulting in the underlying	cause given in Part I	23e. Did tobac	co use contribute to	the cause of death?
ds,	signed I	d by	Tarri, other agriculture			g g	1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Donknown
Ö	law requires as been sign 2 should be	ete					24a. Was an	24b. Were au	topsy findings available
Records,	0 5 6	Completed		· · · · · · · · · · · · · · · · · · ·			autopsy performed	prior to death?	completion of cause of
Vital	ilcian: Th certificate rector, pag	Be Co	25. Was case referred to medical			26. Place of De	1 ☐ Yes 2 ☑ ath (Check only one)	No 1 ☐ Yes	2 NO
Z	ting Physician: A. After this certifications of the second	To B	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3	04	lome 5 Residence	e 6 Other (Spec	city)
n of	ding Ph h. After th funeral		27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how i	injury occurred	
Sio	Attending r death.	catic	2 Accident investigation 3 Suicide 6 Could not be		М	1 ☐ Yes 2 ☐ No			
Division	or Att	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, street, fact fy)	ory, office	28f. Location (Stree City or Town, S		irai Route Number,
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying Ph	ysician: To the best of my kn	owledge, death occurr	ed at the time, date and place	and due to the caus	e(s) and manner as	stated.
	24 h/e Fun	edical		iner: On the basis of examinand manner stated.					
	within To th compl	Me	29b. Signature and title of certifier			29c. License number		Date signed (Monti	h, Day, Year)
			Susanual	Mata	-	RES-000	3	3/31/04	
	ID		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	Wolfe Street			
			31. Date filed (Month, Day, Year)	32. Registrar's Sign	GUO N.	Wolfe Street	t, Baltir	nore, Mo	21287
	Sta Regist	ate rar	APR 0 1 2004	De Was Sign	D Spo	uks.			

Malone 66			•	partment of Health and M Partificate of Death	-	
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Terry 4a. Fecility Name (If not institution, give structure) University Hospi	Lewis	Malone 4b. City, Town, or Location of Death Baltimore	2. Date of Death Month March 29	Day Year 3. Time of Death
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda) Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign Country) 61 MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be notified at once.	To Be Completed by Funeral Director	10a. State MD NA 10e. Street and Number 3119 Artaban Roa 11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced [Specify only highest grade] Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Last) Lewis Edward Mal 19a. Informant's Name/Relationship (Type Mayzel Malone—Wi 20a. Method of Disposition 1X Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signiture of Funeral Service License	2. Was Decedent Ever in U.S. Armed Forces? 1 TSY'es, 2 DNo If Yes, Give Year or Dates: College (1-4or 5+) na 16a. Dec (Give) Interpretation of the completed of the completed of the complete of the comple	10f. Zip Code 21216 3. Was Decedent of Hispanic Origin? (Spelif Yes, specify Cuban, Mexican, Puerto III Yes XINo Specify: Sedent's Usual Occupation we kind of work done during most of working to NOT use retired) 18. Mother's Name Mary Strilling Address (Street and Number or Rura) 3. Attaban Road.	acify Yes or No-Rican, etc.) 16 16 16 17 18 18 18 19 19 19 19 19 19 19	City or Town, State, Zip Code) Pre Md 21216 c. Location - City or Town, State Cbutus, Md
The law requires that the death certificate be executed Example 1	Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, a., bearing to final cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions continued in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of death 5 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	1 ☐ Yes 24a. Was an autopsy	Onset and Death 23d. Date of delivery Month Day Year cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Certification; To Be Comp	27. Manner of Death 1	28e. Place of Injury · At home, farm, building, etc. (Specify) Locating home Ician: To the best of my knowledge, deer: On the basis of examination and/or and manner stated. Locating home Locating	Other: 4 Nursing Ho a of 28c. Injury at Work? 1.3pm 1 Yes 2 No Street, factory, office and hoccurred at the time, date and place, investigation, in my opinion, death occurred CCME	performe 1 15½ Yes 2 1 In (Check only one) 28d. Describe how subject was 28f. Location (Stre City or Town, 2808 Harlen and due to the cau ed at the time, date	death? No 1 Ares 2 No ce 6 Other (Specify) injury occurred assatilted et and Number or Rural Route Number, State) Are. Baltimore, MD se(s) and manner as stated. e and place, and due to the cause(s) d Date signed (Month, Dey, Year) arch 30, 2004
Sta Registi	ate rar	30. Name and address of person who con Taska 2 Gylenb- 31. Date filed (Month, Day, Year) APR 0 1 2004		111 Penn Stree	t, Baltin	nore, Maryland 21201

				For State Registrar	State of Ma	aryland / De	partme ertifica			d Menta		ene s. No. 20 () [10077
		Discolation	,	1. Decedent's Name (First, Middle, Las							te of Death			Time of Death
		Physicia /Medic		Dianne	Louise	Madoni					rch 2	9 ^{Day} 2004		7:21 P M
		Examin		4a. Facility Name (If not institution, give			4b. Cit	_	r Location of D	eath		4c. County of Baltimo		
				Greater Baltimore 5. Social Security Number 6. Se		Center e (In yrs. last birthd	av) if Und	Tows	OII If Under 24 F	Hrs. 8 Dat	te of Birth			(State or Foreign
		Funeral Director			M 2XIF	54 Yrs	Months			Ain. (Mc	onth, Day, '	1950 W	Country) ashin	(State or Foreign
	/land	MOI W		10a. State 10b. County		10c. City, Town o	r Location						· ·	nside City Limits
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2	The the	or 28	Directo	10e. Street and Number			10f. Z	ip Code			10	g. Citizen of Wha	t Country?	
2	ath w	23a	ral	41 Lambeth Bridge				2109	93			U.S.A		
ianne	er de	tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dec If Yes, sp	edent of F ecify Cub	lispanic Origin an, Mexican, Pi	? (Specify Ye uerto Rican,	etc.)	14. Race - Black, 1	Amencan I White, etc.	ndian,
\sim	36 rs aft	', or	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ X If Yes, Give Year or Dates:	NO	1 🗆 Yes	2 □ XNo	Specify:			Specify:	White	_
	215-0036 Ithin 72 hours af	ature Cul E	ted	15. Decedent's Ed	ucation	16a. De	cedent's Us	iual Occup	ation		1	6b. Kind of Busin		
	215 Fin 73	Median.	ple	(Specify only highest gra-	de completed) College (1-4or 5	5+) (G	e. DO NOT	use retire	during most of d)	working				
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no	pu s	d off	Be	17. Father's Name (First, Middle, Last)					_			aiden Sumame)		
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7	Maryland d 2 should be file	Department of Health and Mental Hygiene. Important: or Hems 23a or 28a-f show Important: If Item 27 is marked other than "naturel", or Hems 23a or 28a-f show any injury or other traumatic event, the Medical Exactions must be notified at once.		19a. Informant's Name/Relationship (7										21093
7	.e.	Healt		Cara Madoni 20a. Method of Disposition	Daughter	20b. Place of D	isposition (N	lame of	Tuge G	Date		erville. Oc. Location - Cit		
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	altimore,	ortan ortan injur		21. Signature of Furreral Service Licen		MOCK OIL						Funeral		
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	Ph	ysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.					ratory arres	st,	Inte	proximate erval Between set and Death
		Medical		disease or condition resulting in death)	Due to (or as	a consequence of)	1001	<u>, , , , , , , , , , , , , , , , , , , </u>						
	Ex	aminer		Surroundingly list on williams	, sto	aph h	ne	ins	rechi	5				
	Q	÷	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that stated and the cause of the cause o	Due to (or as	a consequence of)								
	60, be executed	sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to /or as	a consequence of)								
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	687 ifficate	> 9			. d									
	SX 6	attending physic	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		· 🗆					23d. Date of	f delivery	
	Box	ed by the attendir detached for use	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant a	2 Fetal death t time of death	3 ☐Ectopic 5 ☐ Other (y 			Month	Day	Year Year
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	Division of Vital Records, For Attending Physicien: The law requires tha	been signed should be de	ed by F	Part II. Other significant conditions of Penul F	arlure				ven in Part I.			acco use contribu s 2⊈no 3[ause of death?
	aw B	as bee	Completed	Conquest	ve ille	ut tu	lur	C		24	la. Was an autopsy	24b. Wei	e autopsy	findings available stion of cause of
	The Lat	ate ha	E O							10	perform Yes 2	ed? dea	th? Yes 2	
	ita ien:	is certificate director, pag	Be	25. Was case referred to medical examiner?						Death (Chec	ck only one)		
	of V	this coal dire	2	1 ☐ Yes 2 ☑*No	Hospital: 1 X Inpatio			DUA				nce 6 Other	(Specify)	
	Ing P	h. After thi funeral	ion:	27. Manner of Death 1. ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Tim ly Year) 28b. Tim Inju		28c. Inju	ryat rk? ∣Yes 2. □No	280. De	escribe nov	w injury occurred		
	Sici	death ctor: / the	Certification:	2 Accident investigation 3 Suicide 6 Could not be		jury - At home, farm				28f. Lo	cation (Stre	eet and Number	or Rural Ro	ute Number,
	Div	after Direct In by	ertif	4 Homicide determined	building, et	c. (Specify)	, 51,001, 1201	017, 011100		Cit	ty or Town,	State)		,
	Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physicien: The law requires that the death certifical	within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C		ysician: To the best niner: On the basis o and manner st	of examination and/o								
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) [> = 0		Lynthra	man	V Mis		10	0513	47		3/30/	04	
		12		30. Name and address of person who		d	/pe, Print)				-	1 hmes)
	2	Sta		31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	lan	11						
	als.	Registi	rar	MAD 0 1 2004	ATTEMA	for	RESTOR							

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	Examir	er	4a. Fecility Name (If not institution, gi			4b. City, Town, or I		1					
			5. Social Security Number 6.		SPLTAL e (In yrs. last birthde	Carroll Co	Inty If Under 24 Hrs.	8. Date of Birt					
7	Funeral Director			1□ M 2 X F 71	Yrs.	Months Days	Hours Min.	April 12	v. Year)	altimore, Maryland			
	yland sow		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits			
	a-fsh	ctor	Maryland Carroll		Manchester	•				1 □ Yes 2 □ No			
	or 28	Director	10e. Street and Number			10f. Zip Code			-	at Country?			
	a 23a		4412 Jenny Court	AO Was Danidad	T	21102	0-1-1-0-10			Associate Indian			
Maryland 21215-0036	d within 72 hours after death with the Maryland Jene. I than "naturel", or itema 23a or 28a-f show The Medical Examiner court be inclifted at	by Funeral	Narital Status Never Married 2 Married Never Married 2 Married Never Married 2 Divorced	12. Was Decedent Armed Forces? 1 Yes 2X1 If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban □ Yes 2 No	Specify:	pecity Yes or No o Rican, etc.)	Bleck,	White, etc.			
9	2 hou	ted	15. Decedent's E	ducation	16a. De	cedent's Usual Occupat	tion	tina					
218	within 7 ene. than "n	Completed	(Specify only highest g.	College (1-4or 5	i+)	ve kind of work done du DO NOT use retired)	ring most or wor	King	Baltimore, Maryland 10d. Inside City Limits 1				
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and	be la be	Be	17. Father's Name (First, Middle, Las Harry S Reese	(t)					Maiden Sumame)				
Ž	s 1 and 2 should f Health and Men item 27 is marks other traumatic	2	19a. Informant's Name/Relationship	(Type Print)	19h Ma			obertson	er City or Town St	ate Zin Codel			
Ma	and 2 sho salth and n 27 is m		Sharon N Olson	(1),00,1111,		inor Avenue				aro, 219 0000)			
5	item 27		20a. Method of Disposition			position (Name of rematory or other place		Date		ty or Town, State			
E C			1 🖾 Burial 2 □ Cremation 3 1 1 1 2 □ Cremation 3 □ Other (Spec			Memorial Park		2004	Baltimore!	Manyland			
Baltimore,	permit. Page Department of importent: If any injury or once.		21. Signature of Funeral Service Lice	onsee Char	ocki	22. Name and Address Lassahn Funer	ot Facility al Home I	nc		•			
8			23a. Part1. Enter the disease, or cor shock, or heart failure. List on	nplications that caused y one cause on each li	the death. Do not e					Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	Must		unis				Onset and Death			
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):								
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Вох	endin use	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		B⊟Ectopic pregnancy			23d. Date of				
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Σ.	5 6 6	o Be	25. Was case referred to medical examiner? 1X Yes 2 □ No	Hospital:	nt 2 🔀 ER/Outpat	Othor		th (Check only o		· · · · · · · · · · · · · · · · · · ·			
of		F	27. Manner of Death	28a. Date of Inju	ry 28b. Time	of 28c. Injury	4 Li Nursing H		ence 6 Other owninjury occurred	(Specify) UP Truck			
o	nding I th. : After s funer	tlor	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	on 3 Month, Day		Work?		1		18 BU WITH PICK			
Division	I or Attendi after death. Director: A	Certification:	3 Suicide 6 Could not determined		ury - At home, farm,		1	28f. Location (S	treet and Number	or Rural Route Number,			
Ö	s afte	Cert	4 Normale	N. A.	ODDWAY			RT30 1		n cando 40			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best miner: On the basis of and manner sta	examination and/or	ath occurred at the time investigation, in my opi	, date and place nion, death occur	and due to the d	ause(s) and mann	er as stated.			
	within To th	Me	29b. Signature and title of certifier	Ci I		29c. License	number		29d. Date signed (A	Month, Dey, Year)			
			Mounte	Meller	le, m	A	CME		March 2				
	17		30. Name and address of person who	completed cause of d	eath (Item 23a) (Typ	111 Penr	n Street	, Baltin	ore, Mar	yland 21201			
	Sta	ite	31. Date filed (Month, Day, Year)		ar's Signature								
	Registr	ar	APR 0	2004	and K	Course)							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 10079 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nearhoof Betty 6:00 PM Marc 27 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rosedale Inder 1 Year | If Under 24 Hrs. Souare Baltimore Hospital Center Franklin 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min. 1 M 25 F 190-12-5496 Director 81 Nov. 14,1922 Pennsylvania Usuat Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 Yes XXNo Director Maryland Baltimore Berkshire 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7413 Berkshire Road 21224 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 No Specity: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be itam 27 is marked o Chaney Woodring Hannah Richardson 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Heaith and Important: If itsm 27 is n any injury or other traum Mr. Earl G. Nearhoof 7413 Berkshire Road Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Wother (Specify) Entombre 11 Holly Hill Mem. Gdns. 3/31/2004 Middle River, Maryland 21. Signature Turni Servi 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Due lo (or as a consequence of): positive /Medical resulting in death) Examiner abdominal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit certificate be executed retastatic colon enner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 2 yes 2 2 No 3 Ectopic pregnancy Day Year 5 Other (specify) detached 9 Unknown 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performed certificate 2 **Z** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this funeral 28a. Date of tnjury (Month, Day Year) 27 Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: in by the 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the bass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 9c. License number of certifier 29d. Date signed (Month. Dav. Year) 58010

State Registrar

Maryland 21215-0036

Baltimore,

Box (

P.O. I

Records,

of Vital

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Franklin Square Dr. Baltimore MD 21537

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MD

32. Registrar's Signature

Kenneth McDowell
31. Date filed (Month, Day, Year) 32

APR 0 1 2004

			1 - For State Registrar	State of Maryla	and / Depa	artmen rtificat	t of He	ealth and l Death	Mental Hy	giene Reg. No	2001	+ 10080
	Physicia /Medic			DFFILEOZ					2. Date of De Month	h 2ª		4 6.201 W
	Examin Funeral Director		4a. Facility Name (If not institution, give NORTHWEST HOSPITA 5. Social Security Number 6. Security Number 112-20-3448	L CENTER	rs. last birthday) Yrs.		ANDAL	LSTOWN If Under 24 Hrs. Hours Min.		th ay, Year)	ALTIMOR 9. Bir	
	D >		Usual Residence of Decedent 10a, State 10b, County		City, Town or Lo	antina			- UOIXL ZO	, 132	-1717	10d. Inside City Limits
	Aaryla Fahov ed al	or	MD BALTIMO				TOUN					1 Yes 2 No
	28a-	rect	10e. Street and Number	KE	KE13	TERS	Code			10g. Cit	izen of What C	ountry?
:	h with	al Di	12020 REISTERSTOW	N RD.		21	1136			IISA		
2-0036	filed within 72 hours after death with the Maryland Hygiene. titler then "natural", or Items 23a or 28a-f ahow int, tra Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X/Vidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 Yes	dent of His offy Cuban	spanic Origin? (S , Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		14. Race - Am- Black, Whi Specify:	erican Indian, ite, etc. WHITE
ر ر	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece	kind of wo	ork done di	tion uring most of wor	rking	16b. K	ind of Business	s/Industry
7	within ane. then "	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	OMEMA	se retired)			OLIN	ПОМЕ	
7		O a	17. Father's Name (First, Middle, Last)		11	ONLINE		18. Mother's Nar	ne (First, Middle		HOME Sumame)	
	* 6 2 D	To Be	LOUIS	BL	0CK			SARA	Н		BLUM	1
a_<	2 should and Men la marke aumatic		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailie	ng Address	s (Street a		ıral Route Numb	er, City o		
_	5 € Z ±		DAVID OFFICER (SO				RSLE	A CT. C	WINGS M			21117
Baltimore,	00		20a. Mythod of Disposition 1 Burial 2 Cremation 3 F	lemoval from State	. Place of Dispo cemetery, crei	matory or o	other place	.	Date		ocation - City or	
	permit. Page Department Important: I any injury o		*4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens						3/31/0			
ä	Depa Impo		Sint M.	Cittelle	1.			3	OL LEVI			MD 21208
F	Physician /Medical		23a. Part1. Enter the disease, or comply shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. a	EPS1.	ter the mod					V ILLE,	Approximate Interval Between Onset and Death DAYS
	Examiner			Due to (or as a cons	equence of):							
,00	icate be executed physician and s the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to (or as a cons								
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O. Box 6	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic p					23d. Date of de Month	Plivery Day Year
ds, P.O	ires that t signed by d be detac	by	Part II. Other significant conditions con					n in Part I.		obacco u Yes 21		o the cause of death?
Hecords,	fhe faw require te has been sig age 2 should b	Completed		PROSTHES			<u>_</u>	1BRIUA	auto		24b. Were a prior to death?	utopsy findings available completion of cause of
		Be C	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only o	<u> </u>	, , , , ,	2010
> :	Physic this ce al dire	To	1 Yes 2 No	fospital: 1 Inpatient 2			-	4 Industria	lome 5 ☐ Resi	dence	6 □Other (Spe	ecify)
ב	ding Ph h. After th funeral	inol	27. Manner of Death 1 ♀ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. injury Work		28d. Describe	how injur	y occurred	
Division of Vital	or Atten after deat Director; in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe		M reet, factor		es 2□No	28f. Location (. City or To			ural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exami	sician: To the best of my k ner: On the basis of exam and manner stated.	nowledge, death ination and/or in	h occurred vestigation	at the time	e, date and place inion, death occu	, and due to the irred at the time,	cause(s) date and	and manner as I place, and due	s stated. e to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier		0		c. License	142.88		29d. Dat	e signed (Moni	th, Day, Year) 29th 2004
1	3		30 Name and address of person who co	properties of death (III	tem 23a) (Type,	Print)	11 WED	ME	MALC	en	TER	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 1 2004	32. Registrar's Sig	nature							

ORIGINAL

		1 - For State Registrar	State of Maryla	nd / Depa		ealth and M	lental Hyg	giene Reg. No. 200	
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last, Robert Tho 4a. Facility Name (If not institution, give	mas Pat	terso	4b. City, Town, or	Location of Death	2. Date of Dea Month March	ith Dav Ye	54 10; 30 AM
Funeral Director		5. Social Security Number 6. Se 218-05-4260	tended Car x 7. Age (In yr: XM 2□F 85	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 02 01	r, Year)	Birthplace (State or Foreign Country) VA
he Maryland 8a-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County MD NA		City, Town or Lo	ce				10d. Inside City Limits
ultimore, Maryland 21215-0036 nit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: if itam 27 is marked other than "natural", or items 23e or 28a-1 show injury or other traumatic event. It a Medical Exeminar must be notified at 8a.	Funeral	10e. Street and Number 6800 Liberty Ro	ad #816 12. Was Decedent Ever in Armed Forces? 11/2 Yes 2 \[\] No If Yes, Give Year or Dates:	l i	10f. Zip Code 2120 Vas Decedent of His Yes, specify Cubar ☐ Yes ※※No				A . merican Indian,
21215-0036 of within 72 hours af giene. or than "natural", or the Madical Exami	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 7th grade	cation	16a. Deced (Give life. L	ent's Usual Occupa kind of work done du O NOT use retired)	tion uring most of worki		16b. Kind of Busine	
Maryland 2 nd 2 should be filed of the and Mental Hygic 27 is marked other: traumatic event, III	To Be Co	17. Father's Name (First, Middle, Last) Robert T. Patte				18. Mother's Name	(First, Middle,	·	ay Snop
re, Mary 1 and 2 shoul Health and Me tam 27 is mark		19a. Informant's Name/Relationship (Ty Daisy Patterson: 20a. Method of Disposition	-Wife	6800	Liberty	Road	#816,	Baltimon 20c. Location - City	re Md 21207
Baftimore, permit. Pages 1 at Department of Hea Important: If item any injury or othe		1	lemoval from State	cemetery, crem	atory or other place Forest Name and Address	Vet. 4	/5/04	Owings I	
Physician /Medical Examîner		23a. Part 1. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the dealer cause on each line. Due to (or as a conse	MC	r the mode of dying.				Approximate Interval Between Onset and Death
f 60,	Ical Examiner	S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
ath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
COTOS, P.O. I	by	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the un	derlying cause given	in Part I.			to the cause of death? Probably 4 Auriknown
	Completed						24a. Was ar autops perform 1 Yes 2	y prior t	
On Of	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 □ DOA Other: 28c. Injury a Work?	4 Nursing Hon	ne 5 Reside	a) nce 6 □Other (Sp w injury occurred	ροσίη)
UNISING THE OF T	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Special	nome, farm, stre ify)			8f. Location (Sti City or Town	reet and Number or i , State)	Rural Route Number,
LIN To the Hospitel or A within 24 hours after To the Funerel Direc completely filled in by	Medical	29a. Certifier (Check only one) 1	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inve	occurred at the time estigation, in my opin	nion, death occurre	d at the time, da	use(s) and manner ate and place, and do	ue to the cause(s)
7X)		30. Name and address of parton who co	mpleted cause of death (Ite	m 23a) (Type, P	000				1,2004 Center
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	y, D B ature	alto VI	AMC E	stend	'ed Lave	Center

			1 - For State Registrar	State of Maryland / De	partment of Health a ertificate of Death		giene Neg. No. 20 (04 10082
A	Physici /Medic	an cal	Decedent's Name (First, Middle, Las Warren A. Facility Name (If not institution, give	William	Parker 4b. City, Town, or Location o	2. Date of Dea Month March	Day Ye	3. Time of Death
	Examin Funeral Director	C.	Union Memorial 5. Social Security Number 219-18-7319 6. Se	Hospital	Baltimore If Under 1 Year If Under 2 Months Days Hours		n 9.	Birthplace (State or Foreign Country) MD
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD NA	10c. City, Town or Baltimo		,		10d. Inside City Limits XXYes 2 □ No
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 Is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Mudical Examiner must be notified at	by Funeral Director	10e. Street and Number 2505 Overland 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes	10f. Zip Code 21214 3. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☒ No Specify:		U • S • A 14. Race - / Black, V Specify:	_
121215-0036	filed within 72 ho Hygiene. other then "naturent, II.e Medical		15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most b. DO NOT use retired) Dwner 18 Mothe			ction Co.
ryland	should be fi and Mental H s marked of umatic ever	To Be	John William P 19a. Informant's Name/Relationship (1)			abeth Whe	atley	ite, Zip Code)
ore, Ma	es 1 and 2 s of Health an f item 27 is r other trau		Anna Parker-Wi 20a. Method of Disposition 1 \(\mathbb{X}\)Burial 2 \(\mathbb{C}\) cremation 3 \(\mathbb{C}\)	fe 250	O5 Overland A sposition (Name of rematory or other place)	Date	20c. Location - City	
Baltimore, Maryland	permit. Pages Department of I Important: If its any injury or o once.		*4 Donation 5 Other (Specify	Arbutu	s Memorial Pa 22 Name and Address of Facilit March F/H Wes 4300 Wabash A	t		
8760,	Physician /Medical Examiner inhibition and the prival-transit	Ilcal Examiner	23a. Pkrt. Enter the disease, or complete Shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in dealh) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): enter the mode of dying, such as Carcinoma,	1	rest,	Approximate Interval Between Onset and Death 2	
P.O. Box 68	he death certific the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		3 Ectopic pregnancy 5 Other (specify)		23d. Date o Month	,
	w requires that the book of the control of the cont	by	Part II. Dther significant conditions of	ontributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did to		ite to the cause of death? Probably 4 Unknown
al Records,		Completed				1 Yes	prio rmed? dea 2 No 1 □	re autopsy findings available or to completion of cause of th? Yes 20 No
ion of Vital	nding Physicien: 1 tth. :: Alter this certifical e funeral director, p	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Peath 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 ER/Outpa 28a. Vate of Injury (Month, Day Year) 28b. Tim Injury	tient 3 DOA Other: 4 Nu			(Specify)
Division	lal or Attendi s after death. al Director: A ed in by the fu	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S City or Ton	Street and Number om, State)	or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Alte completely filled in by the fune	Medical ((Check only one) Medical Example of certifier	y sician: To the best of my knowledge, d niner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, dea	th occurred at the time,	date and place, and 29d. Date signed (A	due to the cause(s)
	St Regist	ate	30. Name and address of person who Pergrang Garo 31. Date filed (Month, Day, Year)	completed cause of death (Item 23a) (Ty The Linian M. 32. Registrar's Signature	emorial Hos	pital		

			For State Registrar	State of Mary	/land / [Departme <i>Certifica</i>			nd Mental F	lygiene Reg. No.	200	4 10084
	Physicia	an	1. Decedent's Name (First, Middle, Last) Dorothy Brosiu	s Powell					2. Date of Month	Death Day	9 Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give str			4b. Ci	ty, Town, or	Location o			County of Dea	
	CAUTITI		Upper Chesapeak	e Medical	Cente		el Ai:				Harfo	
F	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (II	n yrs. last bii 83	Yrs. If Und	der 1 Year is Days	If Under 2 Hours	Min. 8. Date of (Month, July	Birth Day, Year) 31 19		nthplace (State or Foreign ountry)
	6.00		Usual Residence of Decedent						Joany	<u> </u>	201 20	-
	rylan show	_	10a. State 10b. County	10	oc. City, Tow	n or Location						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r death with the Maryland ams 23a or 28a-f show at trust be rediffed at	Funeral Director	Maryland Harford 10e. Street and Number		Bel		Zip Code			10g. Citiz	en of What C	
	with with	2	1326 Gates Head D	rive				014			USA	
	death ms 23	era		. Was Decedent Eve Armed Forces?	er in U.S.	13. Was De	cedent of His	spanic Orig	gin? (Specify Yes or , Puerto Rican, etc.)	No- 1	4. Race - Am Black, Whi	
1	hours after tural, or ita	by Fur	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:			2 No	Specify:	, r deno riican, etc.,		Specify:	White
21215-0036	2 2 3	Completed	15. Decedent's Educa (Specify only highest grade	ition	16a	. Decedent's U (Give kind of	work done d	urina most	of working	16b. Kin	nd of Business	
212	within Jiene.	шp	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	m	' <i>lite. DO NO</i> 1 eacher		nselo	r	Du	blia E	ducation
, o	be filed with stal Hygiene. of other ther svant, tre		17. Father's Name (First, Middle, Last)	<u> </u>	1	eacher	/ COU		r's Name (First, Mid			aucacion
아나 Maryland	be de la	To Be	Howard H. Bros	ius				Lura	(unk)	Walkup)	
ary -	2 2 2 2		19a. Informant's Name/Relationship (Type	e, Print)	198	o. Mailing Addr	ess (Street a	nd Numbe	r or Rural Route Nu	mber, City or	Town, State,	Zip Code)
	s 1 and 2 of Health item 27 I		Nancy P. Jones /	Daughter		08 West		Lane,	Bel Air,		014 cation - City or	r Town State
iore			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Be		cemete	pry, crematory of ps Ceme	or other place		-3-04		ks, Ma	
29 (permit. Pages Department of Important: If it any injury or once.		*4 □Dopation 5 ☐ Other (Specify) 21. Signature of runnal Service Licensee		00000				1 Home, P		312.7 112	<u> </u>
<u>m</u>	permit. Departm Importa any inju		Hola								r, Mar	yland 21014
~	HINE		23a Part Enter the disease, or complic shock, or heart failure. List only one	ations that caused the cause on each line.	e death. Do						•	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	B:	lale	uail	Pore	eun	noma			2 weeks
	/Medical* Examiner		resulting in death)	Due to (or as a c	onsequence	1	A	10-	0 - 1 1	۸.	,	
		ь	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	consequence	(s) 800	33 IV	lacr	oglobu	len	ia	Hyears
De 1	ansit (Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						V			
50	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a c	onsequence	of):						
3115	cate by	dical	d.						<u>-</u>			
0 x 6	eath certifi attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of						2	3d. Date of de	elivery
B	death e atter	iciar	in the past 12 months?	1□Live birth 2 (4□Pregnant at tin 9□Unknown		h 3∐Ectopid 5 ☐ Other	(specify)			-	Month	Day Year
30.	that the d ed by the detached	hys	9 🗆 Unknown						22- 0			to the cause of death?
dis.	9 G	Completed by Physician/Me	Part II. Other significant conditions cont	ributing to death but i	not resulting	in the underlyin	ig cause give	in in Parti.		_	,	Probably 4 Unknown
Becords	w requirements should	lete							24a. W	. ∕asan	24b. Were a	tutopsy findings available
A	The law	dwo							P	utopsy erformed? s 2'12 No	prior to death? 1 ☐ Ye	completion of cause of
Ta I	ician: Th certificate rector, pag	O O	25. Was case referred to medical					26. Place	of Death (Check or			
- W	Physician: rthis certific ral director,	To B	examiner? 1 Yes 25(No	spital: 1 Inpatient			DOA Othe	4 🗀 140	rsing Home 5 🗆 A			ecify)
≥ no of	ding Pl h. After ti funera		27. Manner of Death 1 Natural 5 Pending	28a. Dale of Injury (Month, Day Y	'e <i>er</i>) 28b.	Time of Injury M	28c. Injury Work	rat ⟨? Yes 2 □		be how injury	occurred	
Port Division	Attending r death. sctor: Afte by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury	- At home, f			.03 20	28f. Locatio			Rural Route Number,
Div	al or A s after al Dire	Certification:	4 Homicide	building, etc.	(Specify)		,		City or	Town, State)		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifier t Certifying Phys (Check only one)		xamination a							
_	o the	Med	29b. Signature and title of certifier				29c. License					nth, Dey, Year)
	- S - O		& Suca	naela	mr	n. D.	Dy	55	30	03	-30	0-2004
_	40		30. Name and address of person who cor	_		Λ. Ι.				7. 1-	- 2 -	mp21014
-	20		S-SLUASALLAN	n, 600		Altro	000	18	oad,	حدالة	T909	MIDAIDIA
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar	-	1 En	De 18 1					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician enning MARCH 31, 2004 1:30A /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 10 M 2□ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural; or items 23a or 28a-f show injury or other traumatic event, the Modical Expenditure; wat be retified at 1 Yes 2 □ No Be Completed by Funeral Director Mary and Number timore 10f. Zip Code 10g. Citizen of What Country? HUE. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 □ No If Yes, Give 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steamshi onaShoreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ ennington 19a. Informant's Name/Relationship (Type, Print) (COUSIN) 19b. Malling Address (Street an Number or Rural Route Number, City or Tail. State, Zip Code, Bolding 1400 30b. Place of Disposition (Name of cometery, crematory or other place) 21207 Mid Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/2004 1 4 ☐ Donation 5 ☐ Other (Specify) parrison forest 21. Signature of Funeral Service Licensee 22221 W. North Ave 21216 23a. Pa 11. Enter the dist ase, or complications that calls of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) **Physician** CEREBRAL VASCULAR ACCIDENT UNKNOWN /Medical Due to (or as a consequence of): **Examiner** Sa usefully list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the 38 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) his certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 1 Yes 2 No 3 Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 Tes 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 1 Yes 2X No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours a To the Funeral D To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) I.K-Wal uslik D0059502 M-D MARCH 31, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JYOTI WALAVALKAR, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902 32. Registrar's Signature 31. Date filed (Morith, Day Year) State Registrar 2004 DHMH 17 Rev 1/2001

ORIGINAL

PENNINGTON,

PHYSICIAN:

KNOWN TO

			For State Registrar		State of	Marylar	nd / Dep <i>Ce</i>	artmen rtificat	t of H	lealth Death	and M	lental Hy	giene Reg. No		10086
			1. Decedent's Name	First, Middle, L	.ast)							2. Date of De Month	ath Day	y Year	3. Time of Death
	Physicia /Medic		Robert	: Andre	w Picker	s, Sr.	·					March	30,	2004	8:32 P M
	Examin		4a. Facility Name (II					4b. City,	Town, or	r Location	of Death			County of Deat	
					re Medica			Tows	on 1 Year	If I Inde	r 24 Hrs.	8. Date of Bi		altimor	
+	Funeral		5. Social Security N		Sex 7 1 € M 2 □ F	. Age (<i>in yr</i> s.	last birthday, Yrs.	Months		Hours		Dec. 1	a <i>y, Year)</i>		nplace (State or Foreign untry)
1	Director	-	239-46-65 Usual Residence of			/U		L				Dec. I	9, 1	933 10.	rth Carolina
N	Maryland -f ahow illed at		10a. State	10b. County		10c. C	ity, Town or L	ocation							10d. Inside City Limits
2	the Maryla 28a-f shor	to	Md.	Balti	more	Tin	nonium								1 ☐ Yes 2X No
P	th the M or 28a-f	lire	10e. Street and Nur	nber				10f. Zip					10g. Cit	izen of What Co	untry?
1-21	death with the ms 23e or 28e	Funeral Director	2206 Fc	orest Ri					210					USA	
		une	11. Marital Status		12. Was Deced	ces?	J.S. 13.	Was Dece If Yes, spe	dent of H cify Cuba	lispanic Oi an, Mexica	rigin? (Sp an, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White	
36	a o E	by F	1 Never Marri	ied 2/ Married	1 ☐ Yes 2 If Yes, Give Year or Da)		1 🗆 Yes	2 🔀 No	Specify	<i>r</i> :			Specify:	Jhite
Kens	within 72 hours ene. then "natural", the Medical Exa	ed		15. Decedent's	Education		16a. Dece	dent's Usu	al Occup	ation			16b. K	ind of Business/	
215	nn 77	ple	(Spec		grade completed) College (1-	4or 5+)	(Give	DO NOT u	se retired	during mo: d)	st of work	ang			
2 2	d with	Completed	Liottoritary	, (, , ,	Š+	,	Engi	neer						ngineeri	.ng
o D	be tiled ital Hygir id other event, I	Be (17. Father's Name			_						e (First, Middle	e, Maiden	Sumame)	
$\frac{\lambda}{a}$	should the marked umatic a	ဥ			Pickens,	Jr.				Ida		nyan			
$\rho_{\mathcal{L}}$	permit. Pages 1 and 2 should be tiled within 72 ho Department of Heath and Mental Hygiene. Importent: If tiem 27 is marked other then "natur any injury or other traumatic event, Ita Medical once.		19a. Informant's Na					•	,					or Town, State, 2	
	1 and 16aith 16aith		Mrs.Hilda		s/ Wite	20b.				-		Date		Md. 210	
Baltimore,	ages or of h		1 ⊠Burial 2	Cremation 3	☐Removal from S		Place of Disp cemetery, cre lakwooc				/ ₁ _6_r	٦/,		gh Point	
草	it. Pa intmer intent njury		* 4 □ Donation 21. Signature of Fu	5 Other (Special in		1 -		2. Name a				14	ПТ	Aii Loriii	ر الال
Ba	perm Depa Impo any i		21. Signature Siry	2	1	marage and administration of		Ruck	Tou	ison l	Funci	cel Hom	e, I	1204	
	STO S		23a. Part1. Enter t	he disease, o	mplications that ca	used the dea	ath. Do not er	iter the mo	de of dyir	ng, such a	s cardiac	uson, M or respiratory a		1204	Approximate Interval Between
	Dhustalas		Immediate Cause	(Final	lty one cause on ea		- 1'0								Onset and Death
	Physician /Medical		disease or condition resulting in death)	in 🔏	_ a	or as a conse									2 (11/3
	Examiner				, Lu	139	Cane	er							5 months
		ner	Sequentially list co if any, leading to in cause. Enter Under	ngitions, nmediate eriving	Due to (d	or as a conse	quence of):								
	be executed sician and burial-transit	Examiner	Cause (Disease or that initiated events resulting in death)	injury s	c										
760,	oe execian a		rosaning in doding		Due to (c	or as a conse	quence or;								
687	a × a	dicai			d										
×	certiff ding	/Me	IF FEMALE: 23b. Was deceden	at programt	23c. If yes, outo									23d. Date of del	ivery
Вох	death atter	clar	in the past 12	months?	4☐Pregna	nth 2 ☐ Fet ant at time of		□Ectopic p □ Other <i>(s</i> ,		<i>'</i>				Month	Day Year
P.O.	t the c by the achec	hysi	9 Unknown		9□ Unkno	wn									
Д.	Physician: The law requires that the death certifica this certificate has been signed by the attending ph rat director, page 2 should be detached for use as th	by Physician/Med	Part II. Other signi	ficant conditions	s contributing to de	ath but not re	sulting in the	underlying	cause giv	en in Part	1.	23e. Did	tobacco	use contribute to	the cause of death?
of Vital Records,	w require been signature											1 🗆	Yes 2	□No 3☑Pr	obably 4 Unknown
့	law re as be 2 sho	Completed										24a. Was	DSV	24b. Were au	topsy findings available completion of cause of
E E	The law cate has page 2	mo:										perf 1 ☐ Yes	ormed?	death?	2 🗆 No
ita	ician: Th certificate rector, pag	Be (25. Was case references	rred to medical							ce of Deat	th (Check only	one)		
) t	hysic his co	ဥ	1 ☐ Yes 2 €				ER/Outpatie			4 🗆 🗅	lursing Ho			6 Other (Spe	cify)
	ding Phys h. After this tuneral dir	ion:	27. Manner of Dear 1 ☑ Natural	5 Pending		f Injury h, Day Year)	28b. Time Injury	of M	28c. Injur Wor	ryat rk? ∣Yes 2.[¬No	28d. Describe	now inju	ry occurred	
(K)	Attending r death. ector: After	Icat	2 Accident 3 Suicide	investigat 6 ☐ Could no	t be 390 Place	of Injury - At	home, farm, s			103 20		28f. Location	(Street au	nd Number or Ru	ıral Route Number,
Division	or A atter Direc	Certification:	4 Homicide	determine	ed buildin	g, etc. (Spec	eity)	troot, ractor	y, omoo			City or To			
_	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeret Director: After this certific completely filled in by the tuneral director.	aic	29a. Certifier	1 ⊆ Certifying	Physician: To the	best of my kr	nowledge, dea	th occurred	at the ti	me, date a	and place,	and due to the	e cause(s) and manner as	stated.
	n 24 h	edical	(Check only one)	2 Medical Ex	caminer: On the ba		nation and/or i	nvestigation	n, in my c	opinion, de	ath occur	red at the time			
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			1 _ For	State of M	aryland / D		t of Heal	th and Me	ental Hy	giene 200	e. 4 10087
			Registrar 1. Decedent's Name (First, Middle, Las				0 0, 500		2. Date of Dea	Reg. No.	3. Time of Death
	Physic	ian	10000	11/	D				Month		
	/Medi	cal	Kenneth		Ross	41. 00	-	V(D - V	03-	30, 0	10:13PM
	Exami	ner	4a. Fecility Name (If not institution, give	street and number)	i /	1)	Town, or Loca	ition of Death		4c. County of	
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	Funeral Director	г	5. Social Security Numbber 6. S. 214–24–4990	X M 2□F 7. AS	ge (În yrs. last birth 75 Y	rs. Months		urs Min.	B. Date of Birt (Month, Day arch 2	6, 1929	Birthplace (State or Foreign Country) MD.
	ъ.		Usuel Residence of Decedent		1 40 - 0' - T						
	ith the Marylan or 28a-f show	_	10a. State 10b. County		10c. City, Town						10d. Inside City Limits
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	death with the Maryland me 23a or 28a-f show crust be notified at	Director	10e. Street and Number			10f. Zip				10g. Citizen of Wha	at Country?
	ath v 9 238		409 Glenwood Road				1014			USA	
	er de	Funerai	11. Marital Status	12. Was Decedent Armed Forces	?	13. Was Dece If Yes, spe	dent of Hispan cify Cuban, Me	ic Origin? (Spec exican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Black,	American Indian, White, etc.
	36 saft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No	1 🗆 Yes	2⊠ No Sp	ecify:		Specify:	White
V	5-0036 72 hours aff		15. Decedent's Ed		169 [Decedent's Usu	al Occupation			16b, Kind of Busin	acc/ladueta/
7	15.	let	(Specify only highest gra	de completed)		(Give kind of wo	rk done during se retired)	most of working	7	TOD. KING OF BUSIN	is same usiny
2	2121 ed within /gjene. er than "	Completed	Elementary/Secondary (0-12) 12 years	Coltege (1-4or	5+)	lf Empl				Seafood F	Restaurant
Senneth	Hyg Sther		17. Father's Name (First, Middle, Last)		100.			Mother's Name (Maiden Sumame)	
2	lan	To Be	James Jeffrey Ros	s			Eu	ılah Ann	Fanni	n	
	Maryland 21215-0036 d 2 should be filed within 72 hours after death with and Mental Hygiene. 27 Is marked other than "natural", or Iteme 23a traumatic event, the Medical Examiliar contains	1	19a. Informant's Name/Relationship (19b.	Mailing Address				r, City or Town, Sta	ite, Zip Code)
S	Ma ith ar ith ar 27 le	1	Vicky L. Ciulla	Daught						r, Md. 21	
A055,	Baltimore, Maryland 21215-0036 Dermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hygiene. Mportant: If Item 27 Ie marked other than "natural", or Iteme 23a or 28a-1 shown may injury or other traumatic event, the Medical Exemptive must be multified at 2008.		20a. Method of Disposition		20b. Place of	Disposition (Nai	_	Da	te	20c. Location - Cit	
E	no ant of tr. if if		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Oak Lay	wn Ceme		April 2004	3,	Dundalk,	мa
	Iltir artme artme ortan injur	1	21 Signature of Fin ral Service Licen		Our Da				-		
	Baltimore, Mar permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 le nr any injury or other treum once.		Whis me			Conne	lly Fur	neral Ho	me Of	Dundalk, Dundlak,	P.A. D. 21222
			23a. Part1. Inter the disease, or com	olications that cause	d the death. Do no	ot enter the mod	le of dying, suc	ch as cardiac or	respiratory ar	rest,	Approximate
	Dissolution		strock or heart failure. List only Immediate Cause (Final	one cause on each I	ine.	1	0				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Heute	MyoCare a consequence of	dial L	ntarct	ion			
	Examiner				chage f	^	moral	- Para	100	A.	
		ē	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a conse uence of		11/10/01	Ternaca	lara	14	
	uted d ansit	ᆵ	cause. Enter Underlying Cause (Disease or injury that initiated events	Stach	LIMARO	115 050	1500	Hinfect	on		5 weeks
), exec n an	Examine	resulting in death) Last	Due to (or as	consequence of	f):	~ J · ~	1111100	0.1		
	ocertificate be executed riding physician and use as the burial-transit	cai		d							
	Box 687(death certificate be attending physical of the Landing physical of th	edi									
	OX cert andin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Detail death	3 ⊟Ectopic p				23d. Date of	f delivery
	Geatte	cia	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant a		5 ☐ Other (sp				Month	Day Year
	P.O.	Physician/Medi	9 🗆 Unknown	9□Unknown							
		by P	Part II. Other significant conditions of	ontributing to death t	out not resulting in	the underlying o	ause given in I	Part I.	23e. Did to	bacco use contribu	te to the cause of death?
	cords w require been signature		Emphysema						1 (X)(Y	es 2□No 3[☐ Probably 4 ☐ Unknown
	as been 2 should	Completed							24a. Was	an 24b. Wei	e autopsy findings available
	Vital Rediction: The law	E							autop perfor	med? dea	r to completion of cause of th? Yes 2 \sum No
	f Vital Re ysician: The l is certificate ha director, page	0	25. Was case referred to medical				26.	Place of Death (165 2 140
	of Vita Physician: this certific ral director,	O.B	examiner? 1 □ Yes 2∰(No	Hospital: 1 🔏 Inpati	ent 2 ER/Out	patient 3 DC	Othor			ence 6 Other	Specify)
	Division of Vital Records, tor Attending Physician: The law requires the effer death. Director: After this certificete has been signed in by the funeral director, page 2 should be or	Ë	27. Manner of Death	28a. Date of Inju		me of 2	28c. Injury at Work?			ow injury occurred	
	ior ath. rr: Aff	atio	1 风Natural 5 ☐ Pending 2 ☐ Accident investigation		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	M	1 Tyes	2 □ No			
	ViS ratte er de recto	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	1 286. Place of in	jury - At home, farr tc. (Specify)	m, street, factor	, office	28	f. Location (S City or Tow		or Rural Route Number,
	Displaying the long of the lon	Cer		3,0	(0,000))					., clary	
1	Division of To the Hospitel or Attending Ph within 24 hours effer death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exam	ysician: To the best niner: On the basis of	of examination and	death occurred /or investigation	at the time, da , in my opinion	ite and place, an	d due to the d at the time, o	ause(s) and manne late and place, and	r as stated. due to the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner st		29	c. License num	nber		29d. Date signed (A	fonth, Dav. Year)
	≥ 1× 1× 8		I must Q	The Os	Imsicia	m L	12/84	6	4	4/1/04	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
			and Name and	nomplated some	double (Home Co.) 7	Tuno Brieti	,			. / /	
	1, 1		30. Name and address of person who	Renden completed cause of Cridian 9 04 32. Phys.	AAA Es	KI - C	Suga T	Drive !	In /tin	MA MA	11737
	St.	ate	31. Date filed (Month Day, Kear)	32. Popisi	accordinature A	BUILD THE	and	JIIVE L	m 1 111	INE PIC	uw/
	Regist		APR UIZU	AUT AUT							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22^{pay} MARCH 2004 DR. ELIZABETH M. RYAN 5:05 PM 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Death BRADFORD OAKS NURSING HOME PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) SEP. 12,1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 F Months 306-40-1163 Yrs. CUMBERLAND, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 ☐ No COLORADO DENVER DENVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2903 S. QUITMAN STREET 80236 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) ELEMENTARY SCHOOL PRINCIPAL **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ISABEL MACDONALD OSBORNE MCINTYRE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JERI HANLY/DAUGHTER 5712 LINDA LANE TEMPLE HILLS, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🛣 Removal from State OAKHILL MAUSOLEUM 3-27-04 4 ☐ Donation 5 ☐ Other (Specify) EVANSVILLE, INDIANA 22. Name and Address of Facility FLECK FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 338 7601 SANDY SPRING RD. LAUREL, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) sclerotic Compounded disagre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one, Other: 1 Inpatient 4 Suursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

The law requires that the daath certificate be executed

efter death.

Director: After this certificeta has to in by the funeral director, paga 2 s

To the Hospital or A within 24 hours efter To the Funeral Director Complataly filled in b

Be

To

Certification:

Medical

State Registrar

or Attending Physician:

Division of Vital Records, P.O. Box 68760

Physician

/Medical

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permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryle Depertment of Heelih end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

altimore, Maryland 21215-0036

by Physician/Medical Examiner attanding physician and for use as the burial-transit been signed by tha should be datached Completed

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menyier of Death

Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 4 ☐ Homicide

Dete of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certif

29a, Certifier

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

04

30 Name and address of be who completed cause of deeth (Item 23e) (Type, Print)

1101 GVin 32. Registrar's Signature

31. Dete filed (Month, Day, Year) 2004

DHMH 16 Rev 6/95

ORIGINAL

			4	For	State of Maryla	nd / Depa	rtment of H	lealth and M	lental Hygi	iene	10000
			1 **	State Registrar	-al	Cer	tificate of	Death	2. Date of Deat	g. No. 2004	3. Time of Death
_		siciar edica		Decedent's Name (First, Middle, Las	Catherine	E. R	icker		Month March	Day Year 27 2004	11:30 PM
		mine	4a.	Facility Name (If not institution, give	4			r Location of Death	L.	4c. County of Death	N/A
				Sinch Hospit	a of Baltin	More last birthday)	BaltiM If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	
	Funer Direct				□M 2√2F 83	Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, April 1	Year) Col. 9,1920 Mai	nplace (State or Foreign Intry) ryland
	pu a	9	-	a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	death with the Maryland ms 23e or 28e-f show	1		,		.,,		eistersto	wn		1 ☐ Yes 2 🖾 No
	h the rr 28e-	1000	106	aryland Balt. e. Street and Number	imore		10f. Zip Code	CIBCCIBCO		Og. Citizen of What Cou	intry?
	ath wit	1 2	2	10 Autumn Wind				21136		United Sta	
	er de:		11.	. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☑ No	J.S. 13.	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
7	036 urs aft	1	Dy C	3₺ Widowed 4 Divorced	If Yes, Give Year or Dates:		I□Yes 25☑No	Specify:		Specify:	White
Ricke	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If lear 27 is marked other then "natural", or Items 23e or 28e-1 shoy any injury or other traumatic event, the Model Examine trust to entitled an	1	11.	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Deced	lent's Usual Occup kind of work done	oation during most of work d)	king	16b. Kind of Business/I	ndustry
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fee	d 2 Hiled Hygi other	Č	17.	9 Years '. Father's Name (First, Middle, Last)		1 111	THISPECE		e (First, Middle, N		22 5-1
6	/lan/ land be Menta Menta irred		0	John Dondorf				Kathe	rine	Guth	
atherine	Maryland od 2 should be flist lith and Mental Hy 27 Is marked oth		19	9a. Informant's Name/Relationship (** · · · · · · · · · · · · · · · · · ·					City or Town, State, Zi	ip Code) yland 21136
2	e, h 1 and 1 and Health em 27		208	Mr. David G. Ri			sition (Name of natory or other place			20c. Location - City or T	
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र्ड	Baltimore, Dermit. Pages 1 an Department of Heal mportant: If item 2.	ouce.	21	Signate of Funeral Service Lices						Dundalk, I	
\mathcal{O}		a	-	1)0.	- (and	$\langle \bigcup \mid 7 \rangle$	922 Wise	Ave. Du	ndalk, M	aryland 21	222
	4	п		3a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the dea one cause on each line.	ath. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Pnysicia /Medic		dis	nmediate Cause (Final isease or condition esulting in death)	aDue to as a conse	Z					10 days
1.1	Examin				PAPHMA	n i a					10 days
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	687 tificate ig phys				u						
	SOX tth cer tendin		23 15	F FEMALE: 3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregi 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy	y		23d. Date of delive	very Day Year
	Records, P.O. Box 68 The law requires that the death certificate has been signed by the attending phy and 2 should be delabeled for use as the		IF 23	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (specify) _				24,
	that the hod by		Pa	art II. Other significant conditions o	ontributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
	ords aquires en sign	1	0 	Coronary	Heart Di	sease	,		1 ☐ Ye	s 2XINo 3∏Pro	bably 4 Unknown
	law re	4 1	Completed	Hypertensio	~				24a. Was ar autopsy	y prior to co	opsy findings available ompletion of cause of
	Vital Recicion: The lay certificate has	Page 1			vasular a	ccide	ents		perform 1 Tes 2	red? death? 2 No 1 ☐ Yes	200 No
	Vita sicien certifi		25	5. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{X} \) No	Hospital: 1 Inpatient 2[TEP/Outpation	t 30 DOA Oth	000	th (Check only one	e) nce 6 □Other (Spec	76.1
	g Phy er this	F .		7. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		y at	28d. Describe ho		19)
	enden eath. or: Aft		atio	1 Natural 5 Pending 2 Accident investigation	n	ligary		Yes 2 □ No			
	Division of Vital Records, torattending Physicien: The law requires that re death. Director: After this certificate has been signed in over the funeral director name 2 should he of	1 1		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location (Str City or Town	reet and Number or Rur , State)	al Route Number,
	Division of Vital Re To the Hospitel or Attending Physicien: The I within 24 hours after death To the Funeral Director: After this certificate he commissive filled in on the funeral director page			9a. Certifier 1 Certifying Ph	nysician: To the best of my kr	nowledge, death	occurred at the tir	me, date and place,	and due to the ca	iuse(s) and manner as	stated.
	he Ho n 24 h	diament in	29	(Check only 2 Medical Examone)	niner: On the basis of examir and manner stated.	nation and/or in	estigation, in my o	pinion, death occur	red at the time, da	ate and place, and due	to the cause(s)
4	To t	3	29	9b. Signature and title of certifier	44.0		29c. Licens			od. Date signed (Month)	**
				100	opmoloted assess of soil "	om 22=\ (T	PAS	- 170	21 1	nurch 2	1; 2004
	10		30	O. Name and address of person who	ing MD S	эт 23а) (Туре,	Hospit	al of	Balt	imme	7,2004
	8	State	-	1. Date filed (Month, Day, Year)	32. Registrar's Sign		100				
	Reg	gistra	r	APR 0 1 2004	A Party	N B	cours				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 17,18 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1730 PM **Physician** RUHL AULINE MARCH >0 2004 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANDALL STOWN SUBACUTE LIHWEST BALTIMORE 0 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Sex X 1 □ M 2 □ F 215-01-1329 Director 99 24, 1904 NEW YORK Usual Residence of Decedent with the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at N/A MD BALTIMORE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a Funerail 3939 ROLAND AVE <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No WHITE Specify: Completed by 3 Widowed 4 X Divorced Year or Dates "natural", 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) CANNING INDUSTRY PRODUCTION WORKER 8 18. Mother's Name (First, Middle, Maiden Sumame)
Clara Kunsbruner
UANNAH KUNSBRUNEL Pages 1 and 2 should be filed nent of Health and Mental Hyginant; if item 27 is marked other 17. Father's Name (First, Middle, Last) William Karpel Be KARPEL ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES WACK (FRIEND) CATONSVILLE, MD 19 N. ROLLING RD. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important; If ite any injury or ot once. 1 ☐yBurial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donetion 5 ☐ Other (Specify) CHEVRA AHAVAS CHESED 3/31/04 RANDALLSTOWN, MD SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a, Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 1 Tes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 2 N 1 Tes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1; Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, After death in by the 1 within 24 hours after deat To the Funeral Director: To the Hospital

Baltimore, Maryland 21215-0036

1 ☐ Yes 2 ☐ No

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N

30

State Registrar

Medical

31. Date filed (Month, Day, Year)

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-I per FH,G830,04/01/04dhb Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 0805 M John Daniel MARCH 29 2004 Steele 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Health Center Bel Air Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **№** M 2□ F 77 230-28-6314 26,1926 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 603 Philadelphia Rd. 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 TYes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No White Specify: 3 ₩idowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Railroad Conductor 12 Passenger Rail Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eugene Vance Steele Barbara (nmn) Jessee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Asbury - Daughter 6 Wright Wing Dr., Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Bel Air Memorial Gard Apr. 1, 2004 Bel Air, Maryland *4 □Donation 5 □Other (Specify) 21009 Approximate Interval Between Onset and Death

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

or 28a-f shov

"natural", or Items 23a

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other traumatic event, the Medical

Baltimore, Maryland 21215-0036

Directo

Completed by Funeral

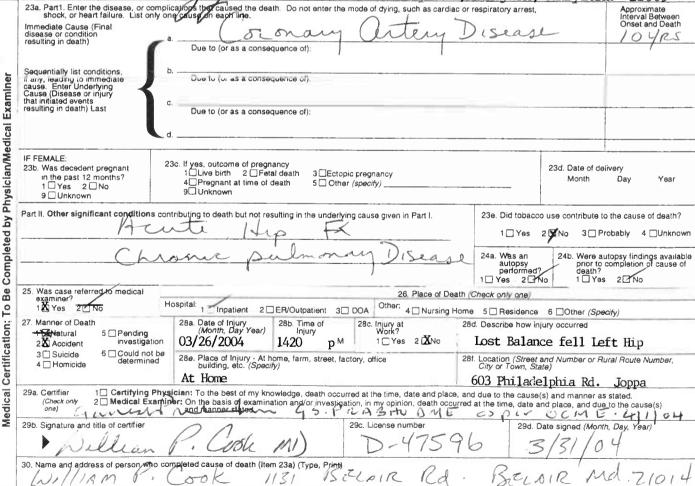
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the attending plant to the total the transfer of the transfer page 2 certificate in by t 24 hours a within 24 hou To the Fune completely fil

Division of Vital Records, P.O. Box 68760.

61141

21. Signature of Funeral Service Licens		Home	
Chunes 4-6	Mg/ 1317 Cokesbury R	d.,Abingdon, Maryl	aı
23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications the caused the death. Do not enter the mode of dving, such as can		
Immediate Cause (Final disease or condition resulting in death)	Coronary artery	Disease	
resolding in death)	Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate	Due to (ui as a consequence of).		
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):		
	1		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1	23d. Date Month	
Part II. Other significant conditions con	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contrib	



State Registrar

To the Hospitel

31. Date filed (Month, Day, Year) APR 0 1 2004 32. Registrar's Signature

			State of Marylar	nd / Depart <i>Certit</i>	ment of H	ealth and Death		giene Reg. No. 20	01	10092
		1. Decedent's Name (First, Middle, Last)					2. Dete of Dea	ith	Year	3. Time of Death
	 Physician / Medical 	Loretta Agnes						27, Day 2004	·	5:00 PM
	Examiner	4a Fecility Neme (If not institution, give s Manor Care Di				Tows		E	of Death Baltin	nore
	Funeral Director	001 00 1213	7. Age (In yrs. 1M 2 F 94		f Under 1 Year fonths Days	If Under 24 H Hours M	in. April 6	7, 1909	9. Birthpla Countr NE	W York
	72 hours efter death with the Maryland natural, or items 23s or 28s-1 show dies Examiner must be notified at eted by Funeral Director	10e. Street end Number 111 West Road	timore		TOWSON 10f. Zip Code 2	21204			Thet Countr	
0020	72 hours efter death values; or frems 23 dides Examiner must efter by Funeral letted by Funeral	1 □ Never Married 2 □ Married 3 □ Married 4 □ Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	10	Yes 2XXXNo	Specify:	(Specify Yes or No- erto Rican, etc.)	Specify.		White
Maryland 21215-0020	C 9 5	15. Decedent's Educ (Specify only highest grade Elementery/Secondery (0-12) 12	cetion completed) College (1-4or 5+)	(Give kind life. DO	t's Usual Occupa d of work done of NOT use retired, retary	luring most of v		U.S. GO	vernn	
yland	d 2 should be filed within the end Mentel Hygiene. 7 is marked other than traumatic event, the M	17. Fether's Neme (First, Middle, Last) William E. Lou		40h M-11/ 4	(60	Agne	lame (First, Middle, S Kratti Rural Route Numbe	nger		On do)
e, Mai	Heali Heali	19a. Informant's Name/Reletionship (Ty) Mr. Charles Jednor 20a. Method of Disposition	ski/Attorney	403 A1	legheny	Avenue	Towson,		nd 212	204
Baltimore,	Pa Pa	XXBurial 2 □ Cremetion 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral \$\(\text{\$\text{Pervice}\$} \) License	Par	'kwood Ce		o of Facility		Baltimor	e, Ma	aryland
Ba	permit. Depertr Imports any inj	Det 7		10	050 York	Road	Ruck Tows Towson,	Maryland	2120	04
	Physician /Medical Examiner	23a. Pert1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.				RE EUMON RIOSCIE		1 1	Approximate interval Between Onset and Death
Box 68760,	certificate be executed ding physician encuse as the buriel-transit and AMedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last		or es a consequen GOGH or as a consequen		ARTE	HIDSCL	1/4- CA-05:15	5	y sais
P.0.	s law requires that the death certific hes been signed by the ettending p je 2 should be deteched for use as mpleted by Physician/Mer	Part II. Other significant conditions con	_	sulting in the unde	rlying cause give	en in Part I.		obacco use con ∕es 2□ No	tribute to	the cause of death?
of Vital Records,	The law requires that are hes been signed by page 2 should be determined.						24a. Was a	an autopsy med?	avai com	e autopsy findings lable prior to pletion of cause eath?
E E	cate he						TOY	is 2KNo	10	Yes 2□ No
ij Š	Physician: The rhis certificate ral director, pag	25. Was case referred to medical examiner?	ospital:		Othe		eath (Check only o			
	this ald	1 Yes 25 No 27. Manner of Death 15 Naturel 5 Pending investigation	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury Work M 1 🗆 Y		3 Home 5 ☐ Resid	ow injury occurre		
Division	To the Hospital or Attending P within 24 hours efter death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	(y)			City or Tow			
	To the Hospital within 24 hours or To the Funeral is completely filled		ician: To the best of my known: On the basis of exemination and manner steted.							
	To the within To the compl	29b. Signature and title of certifier	M.D.		29c. License		9	Date signed	(Month, D	ay, Year) 2004
	40	30. Name end address of person who co	mpleted cause of death (Iter	n 23e) (Type, Prir 7445 F	URNACE	BRANCE	t Rd. GL	ENBUR	NIE M	2004 121060
	State	31. Dete filed (Month, Day, Year)	32. Registrar's Signa		1					

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		1- For State of Maryland / Registrar	Department of Health and M Certificate of Death	ental Hygier	2001. 10000
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	3 25	Oay Year 3. Time of Death Sc. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 212-42-6348 1 M 20 F 60) Usual Residence of Decedent		8. Date of Birth Month, Day, Yea	9. Birthplace (State or Foreign Country)
5-0036 72 hours after death with the Maryland natural; or Items 23s or 28s-1 show dical Examerations to rotified at	Director	10a. State 10b. County 10c. City, To	wn or Location Lim One 10f. Zip Code	10.	10d. Inside City Limits 1-⊡Yes 2 □ No Citizen of What Country?
ter death with the Marylan tems 23a or 28a-f show	Funeral Dir	104 S. Arling for Street 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	· · · · · · · · · · · · · · · · · · ·		14. Race - American Indian, Black, White, etc.
21215-0036 st within 72 hours atter gigne. er then "natural", or ite	þ	1 Never Married 2 Married 1 Yes 2 PNo If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	16b.	Specify: B/ack Kind of Business/Industry
2121 ad within /giene. ier than	• Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)	(Give kind of work done during most of working life. DO NOT use retired) Day (ane Providence Providence) 18. Mother's Name	2	Private an Sumame)
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of Heal		20a. Method of Disposition 20b. Place cemei	tons oromotons or other place!	ate 20c.	althorna MD 21223 Location - City or Town, State ans Jowne MD
Baltimo permit. Page Department Important: If any injury or		21. Signature of Funeral Service Ticensee 23a. Part1. Enter the disease, or complications that caused the death. Di	22. Name and Address of Facility Hari P. Close Ful 109 TESSIER S	neral Sen it, Balt	more, P.A. Approximate
Byteger and hysician and hysician and the burial-transit	Ilcal Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence condition of the con	mel failure incontrollad fartery disa	W.	Interval Between Onset and Death
. Box 6 death certific e attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
cords, P.O requires that the been signed by th should be detache	by	Part II, Other significent conditions contributing to death but not resulting	in the underlying cause given in Part I.	5.4	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
I Rec The law ate has b	e Completed	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed? 1 Yes 2 Y	24b. Were autopsy findings available prior to completion of cause of death? I Yes 2 No
on of ting Phys a. After this funeral di	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/C 27. Manner of leath 1 Natural 5 Pending 2 Accident investigation (Month, Day Year)	Outpatient 3 DOA Cther: 4 Nursing Hon	* ites	orce 6 □Other (Specify) ury occurred
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte	Il Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify) 29a. Certifier Certifying Physicien: To the best of my knowled		City or Town, Sta	
Div To the Hospital or Al within 24 hours after or To the Funeral Direc completely filled in by	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination a and manner stated. 29b. Signature and title of certifier	ge, death occurred at the lime, date and place, a and/or investigation, in my opinion, death occurred	ed at the time, date a	s) and manner as stated. Ind place, and due to the cause(s) Interest and (Month, Day, Year)
7		30. Name and address of person who completed bay e of death (Item 23a	D D0053697	ap	400 1, 2004
St Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 1 2004	SULTA FOLL STRE	et bell	1111100/1111) 2/20

		1	For State	State of I	Maryland /		t of Health and e of Death	d Mental Hygi	ene g. No 2 A A L	10001
	Physicia		1. Decedent's Name (First, Middle,	Last)	542	ver	o or boain	2. Date of Death		3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution,	- /	er)	4b. City,	Town, or Location of D	eath \	4c. Obunty of Death	A
	Funeral		2/3/0/00	6. Sex 1 M 2 X F	Age (In yrs. last t				Year) 9. Birth	nplace (State or Foreign unitry)
	Director		Usual Residence of Decedent 10a. State 10b. County	70 24.	100 City To	wn or Location		DEC. & I	,1949 lenr	10d. Inside City Limits
	e Maryla a-fshov liffed at	.	MD GAR	RETT	FRIE	NDSVI	LE			1 ☐ Yes 2 No
	h with th	al Dire	10e. Street and Number 2734 BLUE	GOOSE	RD.	10f. Zij	531	10	g. Citizen of What Co	Intry?
336	urs after deat el', or Items ?	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Forge ad 1 Tyes 2 If Yes, Give Year or Date	ΣNο PSNο		dent of Hispanic Origin city Cuban, Mexican, Pi 2 No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Amer Black, White Specify:	e, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If tien 27 is marked other than "naturel", or items 23a or 28a-f show important: If tien 27 is marked other than "entirel" or items 20 is not 28 er it shifted at eny injury or other traumatic event, the Medical Examinal must be invitibled at once.	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)			ia. Decedent's Usu (Give kind of wo life. DO NOT	rk done during most of	working	6b. Kind of Business/I	_
Maryland 2	should be filed nd Mental Hygi i marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, L JOHN GE	asi) ISELMA	AN_			Name (First, Middle, M		
	and 2 sho saith and l n 27 is me		19a. Informant's Name/Relationsh	ip (Type, Print) ZEY/daw	1.1	9b. Mailing Addres	(Street and Number o	r Rural Route Number, SCDT 51	City or Town, State, Z	11p Code) 85257
O .	Pages 1 a nent of Hea int: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (Sp		ceme	of Disposition (Na tery, crematory or	me of other place)	1	Oc. Location - City or TANDVE	
Baltir	permit, F Departme Importar eny injur		21. Signature of Funeval Service L			22. Name a		al Home And Crema	ition Center, P.A.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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ı	Examiner	L	Sequentially list conditions, if any, leading to immediate	b	r as a consequenc					J
· 0,	ficate be executed physician and is the burial-transit	Examiner	nf any, leading to immediate cause. Eurier underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	r as a consequenc					
68760,	tificate b ng physic as the bi	ledica		d						
O. Box	that the death certific ed by the attending p detached for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2.☐ No 9 ☐ Unknown	1⊡Live birt	ome of pregnancy th 2 Fetal dea nt at time of death vn	ath 3 ⊟Ectopic p 5 □ Other (s			23d. Date of deli Month	very Day Year
<u>α</u>	w requires that the been signed by th should be detache	٥	Part II. Other significant conditio	ns contributing to dea	th but not resulting	g in the underlying	cause given in Part I.		acco use contribute to s 2 □ No 3 □ Pro	the cause of death?
Division of Vital Records,	The lay ate has page 2	Completed						24a. Was ar autopsy perform 1 Yes 2	prior to c	topsy findings available completion of cause of
f Vita	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No			Outpatient 3 D	OA Cther: 4 Nursi	Death Check only one	nce 6 Other (Spec	zify)
ion o		ation:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	jation	Injury 28t , <i>Day Year)</i>	o. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
Divis	al or Attend s after death il Director:	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 28e. Place of building	of Injury - At home, g, etc. <i>(Specify)</i>	farm, street, facto	y, office	28f. Location (Str City or Town	eet and Number or Ru , State)	ral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical (is of examination			place, and due to the ca occurred at the time, da		
	To the within 2 To the I complet	Me	29b. Signature and title of certifier	£ 2000	le De	25	C. License number	54 25	d. Date signed (Month	1, Day, Year)
			30. Name and address of person	who completed cause	A 0 1	a) (Type, Print)	of Armos	Dr Oal	cland	MD 215TO
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature		Società :	TV UCL	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	

State of Maryland / Department of Health and Mental Hygiene 200 l Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARCH 30, 2004 JOHN EDWARD SEVERN 1:27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner GILCHRIST CENTER FOR HOSPICE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 217-16-1779 Director 82 29,1922 NEW YORK Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 X Yes 2 □ No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö death with 2359 BOSTON STREET 21224 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status 1 Never Married 20 Married 1 XYes 2 No If Yes, Give Year or Dates: 9 Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) CONSULTANT/SALES 12 PRINTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F Т. JOHN SEVERN ANNA BARDROFF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other treu. 2359 BOSTON STREET BALTIMORE MD. EVELYN SEVERN/ WIFE 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) BAYVIEW CREMATORY 3/31/04 BALTIMORE, MARYLAND 21. Signature of Fundamental Service Licenses 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HO
1901 EASTERN AVENUE, BALTO., MD. FUNERAL HOME BALTO..MD. 21231 San Contraction 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer - metastatic Physician months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68768 Physiclan/Medlcal attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a Ö 9 Unknown 9 Unknown σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🔭 ☐ tinknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an performed' 2 No 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Des er (Specify) 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 2 Statural 5 Pending investigation i Director: A 1 ☐ Yes 2 ☐ No death 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, Jarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funeral Completely filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 58303 March 30 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CGOIN-Charles St Baltune UD 21204 Charles mo 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 0 1 2004

3/30/04 1:27pm

		-	For State	State of Marylar		nt of Health and te of Death		_ /	10096
	Physicia	an	1. Decedent's Name (First, Middle, Last MORGAN	LAILA	STANFIEL		2. Date of Death Month	2004	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give Univ. of Mary		1 Syst 4b. Cit	r Town, pr Location of Deat Baltimore	Mar. 24	lc. County of Death	01:20 a ^M
	Funeral Director		5. Social Security Number 6. Se			or 1 Year If Under 24 Hrs Days Hours Min		9. Birth	nplace (State or Foreign untry) ARYLAND
	he Maryland 8e-f show	Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND N	10c. C	ity, Town or Location	+LTIHORE	City	Citizen of What Cou	10d. Inside City Limits 1 ✓ Yes 2 ☐ No
036	be filed within 72 hours after death with the Maryland hat Hygiene. id other than "netural", or Itams 23a or 28e-f show event, I're Madical Examinat must be nedified at	by Funerai	10e. Sfreet and Number 2	12. Was Decedent Ever in I Armed Forces? 1 — Yes - 2 M No If Yes, Give Year or Dates:	ENUE	2122 edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	3	14. Race - Amer Black, White	A , rican Indian,
21215-0036	e filed within 72 ho al Hygiene. I other then "netur vent, I're Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Us (Give kind of w life. DO NOT	ork done during most of wo use retired) MIA	rking	Kind of Business/li	ndustry
Maryland	2 should be file and Mental Hy Is marked oth raumatic event	To Be	17. Father's Name (First, Middle, Last) STERLING T			KIA	me (First, Middle, Maid	J KE	ARNS
Baltimore, Mar	permit. Pages 1 and 2 should Department of Health and Mer Importent: If itam 27 is marke any injury or other traumatic QDC8.		19a. Informant's Name/Relationship (T) HATTE STAN FIE 20a. Method of Disposition 1, Burial 2 □ Cremation 3 □ f 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	CLD(GRAND MOTHE 20b. Removal from State	Place of Disposition (N cemetery, crematory or 2BUTUS ME	ARLINGTO The off other place) ARLINGTO The off other place) ARRIAL O3- And Address of Facility The off other place of the place o	Date 200. -27-04 AI	BALTO / Location - City or T RBUTUS 2. FUNE	TOWN, State HARVLAND KAL HOME
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	Prematur			3 ALTO, 1	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and for use as the burial-transif	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.)					
O. Box 6	원 후 꽃	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregr 1	al death 3 Ectopic			23d. Date of deliving Month	very Day Year
Д	8 6 e	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlying	cause given in Part I.			the cause of death?
of Vital Records,	The law afe has b page 2 s	Completed					24a. Was an autopsy performed? 1 ☐ Yes	prior to co	topsy findings available ompletion of cause of
Ziti	Phyaician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes X X X X X X X X X X X X X X X X X X X	Hospital: 1X Monatient 2	☐ER/Outpatient 3☐ [Out	ath (Check only one) Home 5 ☐ Residence	6 □Other (Spec	ify)
	Attanding Phy ir death. actor: After this by the funeral c	-	27. Manner of Death XX Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in		,,
Division	P H H	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, street, factority)	ry, office	28f. Location (Street City or Town, Sta		ral Route Number,
N	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical C		sician: To the best of my kniner: On the basis of examinand manner stated.					
	To th withir To th	Me	29b. Signature and title of certifier	hashim.	· 2	9c. License number 21 7 3 2 1	^{29d. [} Mar	oate signed (Month, Ch 29,	, _{Day, Year)} 2004
	U		30. Name and address of person who con Nadeem A. Hashm		Greenens t	reet, Balt	imore, Md	21201	
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 1 2000	32. Registrar's Sign	nature -	2. 1/2/			

			For State Registrar	State of Marylar	-	artment of rtificate o			Reg. No. 200	
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last) D A 4a. Fecility Name (If not institution, give s		ITH	4b. City, Town	n, or Location of Deat	2. Date of Dea Month	25 200 4c. County of De	4 4 AM
	Funeral Director		5. Social Security Number 6. Sex	reet M 2016 F 7. Age (In yrs. 47	. last birthday) Yrs.	Balto If Under 1 Ye Months Day	ar If Under 24 Hrs	8. Date of Birt (Month, Da	N/A h, Yeer) 9. 6	Sirthplace (State or Foreign Country) MD
	e Maryland la-f ehow	ctor	10a. State 10b. County MD NA	10c. C	ity, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No
21215-0036	s 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28a-f ehow other traumatic event, the Medicul Erable of must be collined at	Completed by Funeral Director	10e. Street and Number 2413 Etting Str. 11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade	2. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	16a, Dece	Was Decedent of If Yes, specify C	217 of Hispanic Origin? (Suban, Mexican, Puerl	pecify Yes or No to Rican, etc.)	10g. Citizen of What U S S 14. Race - Au Black, W Specify: 16b. Kind of Busines	nerican Indian, hite, etc.
	filed with Hygiene. other than	Be Com	9th grade 17. Father's Name (First, Middle, Last)	nana	Nur	sing A		ne (First, Middle,	Nursing Maiden Sumame)	Home
Maryland	2 should be and Mental is marked c	ToB	Isaac Nathan Ra:	pe, Print)				iral Route Numbe	r, City or Town, State	s, Zip Code)
Baltimore, M	Pages 1 end 2 nent of Health ant: If item 27 i ury or othar tra		Dennis Smith-Hu. 20a. Method of Disposition 1 Burial 2 QCremation 3 B 4 Donation 5 Other (Specify)	20b. emoval from State	Place of Dispo cemetery, crea	osition (Name of matory or other)	g Street place) pry Inc 4	Date	imore Md 20c.Location-City Baltime	
Balt	permit. Pages Department of Important: If if eny injury or o		21. Signature of Funeral Service License	" Kele	2: M	2. Name and Ad larch F	dress of Facility '/H West bash Ave			21215
760,	Physician /Medical Examiner price pr	cai Examiner	23a. Pah11. Enter the disease, or complisher, or hearthallure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a conse	quence of):		an Cerc	or respiratory ar	est,	Approximate Interval Between Onset and Death AMONHS
.O. Box 68	The law requires that the death certificate be execuate has been signed by the attending physicien and cage 2 should be detached for use as the burial-trans	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregna Other (specify,			23d. Date of o	delivery Day Year
4	uires that l signed by ild be deta		Part II. Other significant conditions con	tributing to death but not re	sulting in the u	inderlying cause	given in Part I.	23e. Did to	· V	to the cause of death? Probably 4 Unknown
Il Records,		Completed						24a. Was autop perfor	sy prior t med? death	autopsy findings available o completion of cause of ?
ion of Vital	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	f 28c. Ir	Othor		ne) lence 6 Other (S) low injury occurred	pecify)
Division	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the 14	Medical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, sti	reet, factory, office	се	28f. Location (S City or Tow	itreet and Number or n, State)	Rural Route Number,
	the Hospitef or hin 24 hours afte the Funeral Dir npletely filled in	edical	(Check only 2 Medical Examination)	sicien: To the best of my kn ner: On the basis of examin and manner stated.		vestigation, in m	y opinion, death occu	irred at the time,	date and place, and d	ue to the cause(s)
	To t To t	2	29b. Signature and title of certifier	hlon	no M	29c. Lice	ense number 4283	36	3, 25	
<u></u>	B			AMA, MD	29,5	Print) P	ACA ST			
	Sta Regist		31. Date filed (Month, Day, Yeer)	32. Registrar's Sign	ature	don v				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryland / I	Department of Ho		ental Hygie	2004	10099
			Decedent's Name (First, Middle, Last	St)			2. Date of Death	140.	3. Time of Death
	Physici		SAMUEL	ONEAL	TEDD	V	MARCH	Day Year	1:30AM
	/Medic		4a. Facility Neme (If not institution, give		4b. City, Town, or	Vocation of Death	MARCIT	4c. County of Deeth	71007
	Examin	er	6065 MAR	Cur - T		LTIHOP	25	BAIF	WARE
			5. Social Security Number 6. S	ex 7. Age (In yrs. last bi		If Under 24 Hrs.		9 Righol	ece (State or Foreign
п	Funeral Director			M 2□F 62	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Dey, Ye		PILL ARIA
	*	4	Usual Residence of Decedent	UA			TEDUE	17421114	RYLAND
	/land		10a. State 10b. County	10c. City, Tow	n or Location	-		10	Od. Inside City Limits
	Man Man	tor	MADVIDUA N	12	BA	LTIMO	DRE C	177/	1⊠Yes 2 No
	the 28s	rec	10e. Street and Number		10f. Zip Code			Citizen of What Count	try?
	With Sa or	0	6015 MAD	QUETO ROA	-^	2120	6	1151	
	deeth with the Maryland ms 23a or 28a-f show Linual be codiffed at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of His	spanic Origin? (Spe	city Yes or No-	14. Race - America	an Indian.
10	tter d	F	1 Never Married 2 Married	Amed Forces? 1 X Yes 2 ☐ No	13. Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, White, e	
336	hours atter lural', or Ite	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ₺No	Specify:		Specify: B	MOK
21215-0036	be filed within 72 hours atter deeth with the Marylan hat Hygiene. ed other than "netural", or ftems 23a or 28a-1 show avent, the Medical Examination must be notified at	ted	15. Decedent's Ed		. Decedent's Usual Occupa		166	. Kind of Business/Ind	lustry
75	n nat	Completed	(Specify only highest gra		(Give kind of work done du life. DO NOT use retired)	uring most of worki	ng		
72	iene. r than	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	1 ABO	RER	<	EAFOOD	MAR VET
	filed Hygid Sther ent.		17. Father's Name (First, Middle, Last)				(First, Middle, Mail		1111
an	d be ental ced c	o Be	SAMUEL	TERI	21	MILAR	FA	BARY	SDALE
Maryland	s i and 2 should be f Health and Menta item 27 is marked other traumatic a	은	19a, Informant's Name/Relationship		o. Mailing Address (Street as	nd Number or Bura	I Boute Number Co		
Z Z	nd 2 she lith and 27 ia m r traum		BOTTO TERRIL		OF MA		0.0	0	
-	of Healf item 2 other		20a. Method of Disposition	(SISTER) (of Disposition (Name of	K QUET		. Location - City or Tox	
ō	00		1 ØBurial 2 ☐ Cremation 3 ☐	Removal from State cemete	rry, crematory or other place)		. Location - Only or Tot	MII, Stele
Ë	Pag tment tent: I		' 4 ☐ Donation 5 ☐ Other (Specify	GARI	RISON FORE	ST 04-0	21-04 C	WINGS M	ILLS MD.
Baltimore	permit. Pag Department Importent: I any injury o once.		21. Signature of Funeral Service Licen	500	22. Name and Address	s of Facility	COGUNUT.	R. FUNER	AI HOME
ш	20599		(which	1. William	2140	1. FULT	ON AVE	BALTO,	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death. Do one cause on each line.	not enter the mode of dying	, such as cardiac o	r respiratory arrest.	/	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Motoratati	- 2	Pare		h10-	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence	of):	lince	a wan	Draw	< Imonth
	Examiner				0		Vheto	intable	
16		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	of):				
	d d ansit	F F	Cause (Disease or injury that initiated events						
	ai-trä	Examiner	resulting in death) Last	Due to (or as a consequence	of):				
8760	death certificate be executed e attending physician and id for use as the burial-transit	dicail		4-					
687	phy:	ğ		, d.					
	leath certific attending p	by Physician/Me	IF FEMALE:	23c. If yes, outcome of pregnancy				22d Date of deliver	
Вох	atter for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death				23d. Date of deliver Month	y Day Year
	the de	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	5 Other (specify)				
σ.	The law requires that the de site has been signed by the page 2 should be detached	Ph	Part II. Other significant conditions of	patributing to death but not regulting i	e the wederking on the guide	a in flow I	22a Did tobas	co use contribute to the	a severa of death?
Ś	w requires that been signed be should be det		rantii, Other significant conditions of	onthoding to death out not resulting i	n the underlying cause giver	n in Part I.	_/		
ord	equi	ted					1 QYes	2 No 3 Proba	bly 4 Unknown
BC C	elawr hasbe je 2 sh	ple					24a. Was an autopsy	24b. Were autop	sy findings available ipletion of cause of
œ.	The i	Completed					performed 1 ☐ Yes 2 ☐	death?	
ā		BeC	25. Was case referred to medical			26. Place of Death		10 13.00	
>	Physician: this certific ral director.	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	utpatient 3 DOA Other	T 4 ☐ Nursing Hon	ne 5 Residence	6 □Other (Specify))
0	Ph pr thi	Į.	27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injury	at 2	8d. Describe how in		
0	tun tun	흗	1 Natural 5 Pending 2 Accident investigation		Injury Work? M 1 ☐ Y	? es 2 □ No			
Division of Vital Records,	I or Attending Phatter death. Diractor: After the	Certification:	3 Suicide 6 Could not be		arm, street, factory, office	2	8f. Location (Street	and Number or Rural	Route Number.
\leq	atter Dira	erti	4 Homicide	28e. Place of Injury - At home, fa building, etc. (Specify)	,,,		City or Town, St	ate)	
_	Hospitel 24 hours a Funerel I stely filled	Ö	29a. Certifier 1 ▼ Certifying Ph	ysician: To the best of my knowledge	a death occurred at the time	date and place a	and due to the equa	·/a\d	
2	Hos 24 hc Fun stely	edical	(Check only 2 Medicel Exam	niner: On the basis of examination an and manner stated.	nd/or investigation, in my opi	inion, death occurre	ed at the time, date	e(s) and manner as ste and place, and due to t	ted. the cause(s)
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Med	29b. Signature and title of certifier	and mailler stated.	29c. License	number	294	Date signed (Month, D	lav Yearl
	F 3 7 8	-	255. Signatura and into or continor	1.40	10 1	(00	234.	2 2 1	Ly, 1041)
^	1		- Marinaran Ch	nun MID	111/	6 78		0120105	
12	11		30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print)		0 . (2	
1			KATHRING CHU	A 10 Nort	h Greene	St, 1	Gultimo	re 212	101
	Sta	147	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1. 1				
	Registr	ar	APR 012	004 General	D Local	1			

DHMH 17 Rev 1/2001

ORIGINAL

			1- For State of Maryland / Department of Maryl	artment of Health and		ne 2004 10100
	Physic	ian	1. Decedent's Neme (First, Middle, Last) Sandra A. Turner		2. Date of Death Month	Day Year 3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	March 29	2004 3:30 PM ^M 4c. County of Death
- 53	Funeral Director		15 Tentmill Lane #L 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 173–46−9428 1 □ M 2 ↑ F 45	Pikesville If Under 1 Year If Under 24 H Months Days Hours Mi		Baltimore 9. Birthplace (State or Foreign Country) Pennsylvania
	anyland •how	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits
	h with the N 23a or 28a-f at be notifi	Funeral Director	Maryland Baltimore Pikesvil 100. Street and Number 15 Tentmill Lane #L	Le 10f. Zip Code 21208		1 Yes 2 No Citizen of What Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Itema 23e or 28a-f show any injury or other traumatic event, the Medical Expedical Executate trausle at 2002.	by Funer	Amed Forces? I Married 2 Married 1 Yes 2√ No	Nas Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ▼No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036	ithin 72 hou ne. nen "neture nen "neture	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	rorking 16b	b. Kind of Business/Industry
and 21	be filed wintal Hygien of other the	Be	17. Father's Name (First, Middle, Last)	18. Mother's Na	ame (First, Middle, Maid	,
Maryl	od 2 should Ith and Me 27 le mark traumatio	To		g Address (Street and Number or F		ty or Town, State, Zip Code)
altimore,	Pages 1 ar nent of Hea ant: If Item ary or other		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State 20b. Place of Dispo	sition (Name of natory or other place) ematory Inc. 3-3		s, PA 15010 Location - City or Town, State altimore, MD
Balt	permit. Departi Imports any injt		21. Signature of Tonacal Service Upensee 22 Thomas Gregor	Name and Address of Facility Premation Society 199 Frederick Ros	y of MD, In ad Baltim	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	er the mode of dying, such as cardial three Breas	ac or respiratory arrest,	Approximate Interval Between Onset and Death 4 years
## 67	certificate be executed Iding physician and Ise as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
O. Box 68	certific Iding p	Physician/Medic		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Hecords, P.	The law requires that the death te has been signed by the atter age 2 should be detached for u	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑ Unknown
_	10 11	Completed			24a. Was an autopsy performed?	
Vital	Phyaician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 12 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	04	eath (Check only one)	
Division of	fing Pt	Certification; T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Investigation 2 Significant For Could not be	28c. Injury at Work? M 1 □ Yes 2 □ No	Home 5 Residence 28d. Describe how in	jury occurred
N	To the Hospital or Attanding within 24 hours after death. To the Funaral Director: After completely filled in by the fune.	I Certifi	4 Homicide determined 286. Place of thury - At home, farm, stre building, etc. (Specify)		City or Town, Sta	
	o the Hos vithin 24 ho To the Fun completely	Medical	29a. Certifier (Check only only) 29b. Signature, and title of certifier	occurred at the time, date and place estigation, in my opinion, death occi	urred at the time, date a	(s) and namer as stated and place, and due to the cause(s) Date signed (Month, Day, Year)
	- > - 0	A STATE OF THE STA	30. Name and address of person who completed cause of death (Item 23a) (Type, F	D18667		ch 30,2004
	\ Sta	te	Philip Militello, MD 6 Trumble Hill 31. Date liled (Month, Day, Year) 32. Registrar's Signature	1 CT. Lutherwill.	e, Marylanc	21093
DHM	Registr	ar	APR 0 1 2004 5	ouks		
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State of Maryland / Department of Health and Mental Hygiene 2004Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** march 4:40 D. M. Judith Тус $\alpha \omega$ /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number 4c. County of Death Examiner n Klin Square Hospita Kosedale If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) November 24, 1943 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 TF 212-44-6973 60 Yrs. Director MD. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examinat must be notified at 10d. Inside City Limits Director MD 1 ☐ Yes 2 No Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1930 Ormand Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 200 Married 1 ☐ Yes 2X No Specify: Specify: White چ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Keypunch Operator I.C. Isaacs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Conrad Hetterich Inez Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Tyc husband 1930 Ormand Road Dundalk Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery Brooklyn, MD. 4 Donation -5 Other (Specify) 2004 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** astr tion. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed and I-trans Due to (or as a consequence of): attending physician a for use as the burial Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? څ 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 212 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Medical Certification: 1 Natural 5 Pending investigation To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and tit 29d. Date signed (Month, Day, Year) Name aptragloress of person who completed cause of death (Item 23a) (Type, Print) Dr. Stephen Selinger 9000 Franklin Square Dr. Baltimore, Md. 21237 31. Date filed (Month, Day, Year) APR 0 1 2004 32. registrar's Signature State Registrar

				State of Maryl				-		e.
		•	For State Registrar	otato or mary.		rtificate of			g. No 200	4 10102
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	Funeral		560 S. BEECHFU 5. Social Security Number 6. Se.		UE vrs. last birthday)	BALTIM If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign
	Director		218 · 12 · D437 10 Usual Residence of Decedent	M 264 76	Yrs.	Months Days	Hours Min.	09-02-		Country)
200	show	-	10a. State 10b. County		City, Town or La					10d. Inside City Limits 1 Yes 2 □ No
M of	28a-1	Funeral Director	MD NIA	10	ALTIMO	10f. Zip Code		11	0g. Citizen of Wha	
4	23a or	al Di	567 8. BEECHFIE	AN AVEN	uE	2122	29		USA	•
rop .	Itema 2	iner	11. Marital Status	12. Was Decedent Ever i	n U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race -	Americen Indian, White, etc.
036	5 6 E	þ	1 ☐ Never Married 2 ☐ Married 3 🗷 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	,	Specify:	BLACK
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d 2	I Hygiene. other than	Be Co	17. Father's Name (First, Middle, Last)		0,101.	J 11.11.02	18. Mother's Name			
ylar	and Mental is marked o	To B	WILBUR WATSON				MARTHA	WAR	£	
<u>a</u>	and is m	1 8	19a. Informant's Name/Relationship (Ty VERONICA GRINA		19b. Maili	S. BEE	and Number or Run	4 - 4 -	- A	1= 01000
	Health tem 27		20a. Method of Disposition		b. Place of Dispo	sition (Name of		-	3ALTO . (20c. Location - Cit	y or Town, State
OE .	nent of int: If it		1 Burial 2 Cremation 3 F 1 Donation 5 Other (Specify)	lemoval from State	cometery, crea T-XION	matory or other plac		2.04 E	BALTO.N	10
Baltimore,	Definit. rages I and Department of Health Importent: If item 27 any injury or other tr once.		21. Signature of Fundral Service Licens	-			ss of Facility Fu			
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	hysician /Medical xaminer		23a. Part1. Entek_the disease, or complete shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	PSIS	De Ce				Approximate Interval Between Onset and Death
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P.O. Box 687	e atter d for u	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 100 miles.	etal death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	delivery Day Year
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of Vital Records,	2 5 6	Completed	Deabele	<u>.</u> 8.				24a. Was an autopsy perform	prio	
/ita	ertifica actor,	Be	25. Was case referred to medical examiner?	1			26. Place of Death			
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Vision	th. : After s fune	ation	1 utural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work	Yes 2 □ No	EDG. Describe NO	w injury occurred	
5	i gitt	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number o State)	r Rural Route Number,
] Jetinson	24 hours e Funere	Medical	29a. Certifier 1 Contifying Physical (Check only one)	sician: To the best of my liner: On the basis of examand manner stated.	knowledge, death ination and/or in	n occurred at the tim vestigation, in my op	ne, date and place, a pinion, death occurr	and due to the car ed at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)
) L	withir To th comp	Me	29b. Signature and title of certifier	berg		29c. License	9 number 26745	29	d. Date signed (A	lonth, Day, Year)
	7		30. Name and address of person who co	11 4419	IFA LL	Print)	BALT	POMD	21211	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 1 21	32. Registrar's Sig	gnature	town .				

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Kenneth W. Watkins 3:40 AM 2004 Karch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cety HOSpital Beltimor Bolti more N/A If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 213-32-5996 69 Director 1935 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City. Town or Location IOd. Inside City Limits 7 is marked other than "natural", or items 23e or 28e-f show traumatic avant. If a Modical Examit at must be multified at N/A Maryland Baltimore WYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4409 Buchanan Avenue 21211 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married ★▼ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 12 1 No Specify: white 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Traffic Engineer Baltimore City 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Itam 27 is marked oth any jinyr or other traumatic avant 2008. Howard Watkins Katie Viola Cooley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4409 Buchanan Avenue Baltimore, Maryland Marilyn Watkins Wife 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 4/3/2004 Woodlawn, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21. Signatura Funeral Service Licensee se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one pause on each line. Part . Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Renol Physician Ketastatic Cell Corcenomo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): igned by the attending physician be detached for use as the buria Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diohetis Prostate Kellitus Cancer 1 Tes 2 No 3 Probably 4 □Unknown Secondowol 24b. Were autopsy findings available prior to completion of cause of death? Scenure 24a. Was an Disorder autopsy performed? Yes 2 No 2 No Depresion 1 Yes 1 Yes Division of Vital or Attanding Physicien: 25. as case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28b. Time of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation after death. М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier Bradauslivite RES -MD Karch 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRADAUSCAITE HOSPITAL OF BALTIMORF M.1) 31. Date filed (Month, Day, Year) APR 0 1 2004 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

KENNETH

WATKINS

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			1 - For State Registrar	State	of Marylan	d / Depa		t of H	ealth a		-	giene Reg. No 20	04	10104
ı	Physicia	an	Decedent's Name (First, Middle ANNE	le, Last)		WASS	ERMAN				2. Date of De	37	Year	3. Time of Death
>	/Medic Examin		4a. Facility Name (If not institutio	n, give street and no	umber)		4b. City,	Town, or	Location of	of Death		4c. County		1:10A M
			LEVINDALE	0.5	7 4-0 (1-1-0)	and bloth do. 1	If Under		MORE If Under	24 Hrs	0. Date of Bir		/A	- (C)
ł	Funeral Director		5. Social Security Number 215-42-1989	6. Sex 1 □ M 2 1 1 F	7. Age (In yrs. I 94	Yrs.	Months	Days	Hours	Min.	DEC th 25	th Y# 1 909	9. Birthp Cour	place (State or Foreign MARYLAND
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						1	Od. Inside City Limits
	Maryl a-f sho	tor	MD N,	/A		BA	LTIMO	RE						1X Yes 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Item dical Examination until be multiled at once.	Funeral Director	10e. Street and Number 3601 FORDS LA.	#915			10f. Zip	Code	212	15		10g. Citizen of	What Cour	ntry?
	death v	neral	11. Marital Status	12. Was Dec	pedent Ever in U.	S. 13.	Was Deced	ent of Hi			ecify Yes or No Rican, etc.))- 14. Rad	ce - Americ	
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Maryland 21215-0036	d 2 shoth and the and the modern traum		19a. Informant's Name/Relations									er, City or Town,		Code)
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Ba	permit. Departr Importe any Inju		21. Signature of Funeral Service	icensee	MA	22	. Name and			302		SON & BR PIKESVIL	-	
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99 xc	certific nding p use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna							23d. Da	te of delive	erv
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Vital Records,	w requires that s been signed b should be det	ed by	Cardismys	rathy	Con	pestiv	e t	teant	fa	ilni	e 10.	Yes 2 No	3 🗌 Prob	ably 4 Unknown
eco	tawrenas bee	Completed	typetension	γ , \mathcal{O}	ementix	<u> </u>	Atri	f-	febru	(lati	24a. Was	DSV	prior to cor	psy findings available mpletion of cause of
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of Vil	Physicien: r this certific ral director,	To B	examiner?	Hospital:	Inpatient 2	ER/Outpatien	t 3 DO	A Othe			h <i>(Check only c</i> me 5□Resi	dence 6 □Oth	er (Specif)	y)
o uc	Jing After		27. Manner of Death 1 XNatural 5 ☐ Pendi	28a. Date (Mo.	of Injury oth, Day Year)	28b. Time of Injury	M 2	Bc. Injury Work	at ? /es 2 □		28d. Describe	how injury occur	red	
Division	Attending or death. ector: After by the fune	Certification:	2 Accident invest 3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	e of Injury - At ho ding, etc. (Specify	me, farm, str					28f. Location (City or To	Street and Numb	er or Rura	l Route Number,
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	To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only 2 Medical one)	ng Physicien: To the Exeminer: On the and ma	basis of my know basis of examinat nner stated.	ion and/or in	estigation,	in my op	e, date an inion, dea	d place, th occuri	red at the time,	date and place,	anner as st and due to	tated. the cause(s)
	To the To the Comp	Z	29b. Signature and title of certific	er .			29c	. License	number	~		29d. Date signe	d (Month,	Day, Year)
,			30. Name and address of perso	who completed rai	ise of death (Item	23a) (Type	Print)	/ O @ {	0017	,		3/30	1/20	7
_			A. Ghazin	our	Levin	dale	24	341	W.B	elve	deve f	tre. Ba	Hemo	re, MD
	Sta	ite ar	31. Date filed (Month, Day, Year APR 0 1 2004	32.	Registrar's Signat	ture								

			1 - State Amend Item Registrar	State of 23b-c, p	of Marylar t.II,25	nd / Depa ,27 ,28	artment of H	lealth a	and Mer 3 5-11	ntal Hyd	giene as	200	4 10	105
Е			1. Decedent's Name (First, Middle,	Last)						Date of Dea Month	ath Dev	Yea	3. Time of	Death
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	Examin		4a. Fecility Name (If not institution,	give street and nu	mber)		4b. City, Town, or	Location o	of Death			ounty of D		
		H,	Ivy Hall Nursing				Middle					altim		
	Funeral			6. Sex 17∑M 2 ☐ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birtl (Month, Day	y, Year)	9. 6	Birthplace (State o Country)	r Foreign
	Director		219-76-0350 Usual Residence of Decedent	A -	4	l6 Yrs.			Jı	uly 20) , 195	7 M	D	
	land ow		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						10d. Inside Ci	ty Limits
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	h witl	al D	2030 Kelmore Roa	ad			21222	?			U	SA		
	deal	ner	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig	gin? (Specify	Yes or No-	. 1.	Race - A Black, W	merican Indian,	
9	or It	by Funeral Director	1 Never Married 2 Marrie	ed 1 ☐ Yes If Yes, G	2 X No ve		1 ☐ Yes 2 ☐XNo	Specify:					White	
Š	hours.	q p	3 Widowed 4 Divorced	Year or D	ates:	160 Dece	death House Occurs							
7	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or tame 23a or 28e-f show that the Medical Examination must be notified at	Completed	15. Decedent (Specify only highes	grade completed)		(Give	tent's Usual Occupa kind of work done of DO NOT use retired	durina most	of working		100. Kin	of Busine	ss/Industry	
21215-0036	filed with Hygiene. other ther	mo	Elementary/Secondary (0-12) 12 Years	Coltege (1-4or 5+)	Brick	laver			ŀ	Cons	truct	ion	
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<u>a</u>	should be and Mental marked o	To B	Anthony T. Yoo	r Sr.				Regi	ına Ste	ein				
Maryland	2 should be filed within and Mental Hygiene. Is markad other than eumatic event, Ita M		19a. Informant's Name/Relationsh				ng Address (Street a							
	and sealth m 27		Regina De Voe	Si	ster		Cameron C	ourt,						
Baltimore,	Pages 1 and 2 should been of Health and Ments int: if item 27 is marked int; or other treumatice		20a. Method of Disposition 1 ☐ Burial 2X Cremation	3 □Removal from	State	cemetery, crer	sition (Name of natory or other plac	e)	April	1,	20c. Loc	ation - City	or Town, State	
	t. Partmen tant:		'4 □Donation 5 □ Other (Sp		Bay		rematory	1.0	2004				City, MD	
Ra	permit. Pages Department of Important: If it any injury or o		21. Signature of Fundral Service L	ICODS OF	7	Č	Name and Address onnelly F 110 Solle	unera	1 Home	e Of I	Dunda	lk,P.	A. 21222	
8			23a. Print. Enter the disease, or shoot in heart failure. List of	complications hat	caused the dea							111,110	Approximate	•
	Physician		Immediate Cause (Final	only one cause on	ANOX		NCEPHA						Interval Bette Onset and D	Death
	/Medical		disease or condition resulting in death)	a. Due to	(or as a consec	quence of): N	larcotic i	ise	,,				13 0000	<i>Y)</i> ,
88	Examiner		Sequentially list conditions,	b	AIC	onol	A PU.	Je						
	De is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(u. as a corisor	Juence of).	Abuta	2	^	-1				
_	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial transit	хаш	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):	POP		1		10	7		
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687	ficate p physics to the			0				FRT	IEIO ANON AP	STACKET				
×o	eath certific attending pl	N/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn				V		23	d. Date of	delivery	
ň	death	Physician/Med	in the past 12 months?		oirth 2 ☐ Feta nant at time of o		Ectopic pregnancy Other (specify)		/			Month	Day Y	'ear
о. О	at the de by the a stached	hys	9 Unknown											
ś	res that igned b	by	Part II. Other significant condition Alcohol abuse	ns contributing to o	leath but not res	sulting in the u	nderlying cause give	en in Part I.					to the cause of d	_
ord	w requir been si should I	Completed	ATCOROL ADUSE							1 ⊔ Y	es 2	No 3∐	Probably 4 20	nknown
Records,	law law las b	nple						<u></u>		24a. Was a autop:	sy	prior t	autopsy findings a o completion of ca	available ause of
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<u> </u>	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe		of Death (Cl					
o	Phys this ral dii	To	1 A Yes 22 No	28a. Date		ER/Outpatien	t 3 DOA 28c. Injury Work	at Nur	rsing Home	5 🔲 Resid Describe h			pecify) unk	
O	ding F. After funer	tlon	1 □ Natural 5 □ Pending 2 □ Accident investig	Found	h, Day Year)	Injury	Work	k? Yes 2 X IN		. 50001150 11	OW III July	boodiiod	Carrie,	
Division of Vital	ovattending Physicien: atter death. Director: Atter this certification by the funeral director.	ifica	3 Suicide 6 Could n	ot be 28e. Place	of Injury - At h	ome, farm, str	eet, factory, office		28f.	Location (S	treet and	Number or)2030 Ke	per,
á	s atte	Certification:	4 Homicide	Dulid	ing, etc. (Speci nd)at h	ome			Rd	., Dun	n, State) 1da1k	rouna ,MD)2030 Ke	Imore
17	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical (29a. Certifier (Check only one)	:xaminer: On the b	e best of my kno basis of examination	owledge, death ation and/or in	n occurred at the time restigation, in my op	ne, date and pinion, deat	d place, and h occurred a	due to the c at the time, d	ause(s) a late and p	nd manner lace, and d	as stated. ue to the cause(s)	
	o the o the omple	Mec	29b. Signature and title of certifier	and mar			29c. License			2	29d. Date	signed (Mo	onth, Day, Year)	
	F 3 F 8		10	un			DRO	641			Marc	h 31	20011	
	1		30. Name and address of person v	vho completed cau	se of death (Ite	m 23a) (Type.	Print)	-T	. 0		0		7	,
_	J		RAMESH SABA	PATH S	101-109		Print) RIVER	NEC	ve Ko	CIA	13AL	MOR	emnryla	192121
	Sta Registr		31. Date filed (Month, Day, Year)	1	Registrar's Sign	ature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 State Registrar AMEND ITEM #7&8 PER FH G830 4/02/04Contificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April 5:00 P M 2004 Leroy C. Adams 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Baltimore 3211 Hilltop Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1936 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 11 M 2□F -69 - 68219-32-8776 March 7. 1935 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b, County 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 3211 Hilltop Avenue 21227

1 ☐ Yes 2 🔀 No

Railroad Technician

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

14. Race - American Indian, Black, White, etc.

Rail Transportation

Specify:

18. Mother's Name (First, Middle, Maiden Sumame)

Ruth U. Sheeler

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16b. Kind of Business/Industry

23d. Date of delivery

Dav

24b. Were autopsy findings available prior to completion of cause of death?

2 No

1 Yes

Month

White

Approximate Interval Between Onset and Deathy

5 Months

Year

event, the Medical Examiner must be notified at Pages 1 and 2 should be filed within 72 hours after death Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 ie marked other than 'eny injury or other traumatic event. Le Me

Physician

/Medical

10a. State

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

Donald L. Adams

15. Decedent's Education (Specify only highest grade completed)

Funeral Director

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Completed

Be

2

Examiner

Funeral

Director

Physician /Medical Examiner

sician and burial-transit

the attending physician

use

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death certificate be executed

Box 68760

P.O. 1

Division of Vital Records.

or Attending Physician: after death. Director: After this certifica

To the Hospital of within 24 hours a To the Funeral D

as the filled in by the I

Examiner Physician/Medical þ Completed Be Certification: To Medical

3211 Hilltop Avenue, Baltimore, Maryland 21227 Betty I. Adams/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Gar. 4/5/2004 Sykesville, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licenses or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final tas 911 disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 DEctopic pregnancy 2 Fetal death 1 I ive birth in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 220 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give

Year or Dates:

College (1-4or 5+)

State Registrar 31. Date filed (Month, Day, Year) APR 0 2 2004 32. Registrar's Signature

6

		•	For State Registrar		of Marylan	nd / Depa	artment of H	lealth a Death	and M	F	Reg. No.	04	1010
	Physicia		1. Decedent's Name (First, Middle, MARVIN VINCENT		N					2. Date of Dea Month MARCH 3		ear	3. Time of Death 8:45 AM
	/Medic Examin		4a. Facility Name (If not institution,		ımber)		4b. City, Town, or BOWIE		of Death		4c. County of PRINC		ORGES
	Funeral Director			6. Sex 1 _XM 2 ☐ F	7. Age (In yrs. 81		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day MARCH]	Year) 1923	Birthpl Count NEW	ace (State or Foreign ry) JERSEY
Maryland	fabow fied at	tor	Usuel Residence of Decedent 10a. State 10b. County MD PRIN	CE GEORGE		ty, Town or Lo	ocation					10	od. Inside City Limits
with the	or 28a	Director	10e. Street and Number	O.M.			10f. Zip Code 2071	15			10g. Citizen of What	at Coun	try?
U Z I Z I 3-0030 filed within 72 hours after death with the Maryland	ital Hygiene. id other than "natural", or Items 23a or 28a-f show event, the Medical Examinat must be multiple at	by Funerai	16 301 OXFORD 11. Marital Status 1 Never Married Married Married Involved All Divorced	12. Was Dec	Ne 42-		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No			ecify Yes or No- Rican, etc.)		America White, a	etc.
Within 72 hou	ene. than "natura he Medical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	during mos d) 	t of work	ing	16b. Kind of Busin	ness/Ind	lustry
2 2	e d a	o Be Co	17. Father's Name (First, Middle, ROBERT ACKERM		†		(TEEE CERT	18. Mothe		(First, Middle,	Maiden Sumame)		
Maryla 12 should	is		19a. Informant's Name/Relations! MURIEL MARIE		/WIFE		ng Address <i>(Street</i> 301 OXFORI			IE, MD	or, City or Town, St. 20715	ate, Zip	Code)
s 1 and	of Health if item 27 ir other to		20a. Method of Disposition		20b.	Place of Disp	osition (Name of matory or other place		(Date	20c. Location - Ci	ty or To	wn, State
SAITIMON Dermit. Pages	돈만큼.		1	pecify)	MAI		CEMETER 2. Name and Addre		4/3/:	-	GORDONS EVANS FU		
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/bU,	ys e	cai Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	o (or as a conse	uuence of):	men's uri us	y o	utf	lov	o bshuc	hr	Onset and Death
.C. BOX bB the death certifical	by the attending physicached for use as the t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregribinth 2 Fet gnant at time of nown	al death 31	□Ectopic pregnanc □ Other (specify)	у			23d. Date Month		ry Day Year
J &	r signed by	b	Part II. Other significant condition	ons contributing to	death but not re	sulting in the	underlying cause giv	ven in Part	l.	23e. Did t	obacco use contrib Yes 2 No 3		e cause of death? ably 4 □Unknown
Vital Records, P.O.	ate has been page 2 shouk	Completed								24a. Was autor perfo 1 Yes	osy pri	or to cor ath?	psy findings available appletion of cause of
VITA VICION:	r this certificate has	Be	25. Was case referred to medica examiner?	Hospital:	Therefore Of	750/0-4-44	Ott	hac		h (Check only c	one) dence 6 □Other	/Specifi	()
DIVISION OF VITA	th. After this funeral di	tion: To	1 Yes 2 No 27. Mann of Death 1 Natural 5 Pendir 2 Accident investi	28a. Dat (<i>M</i> c	Inpatient 2 [e of Injury enth, Day Yeer)	28b. Time Injury	of 28c. Inju				how injury occurred		9
DIVISI	within 24 hours after death. To the Euneral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could 4 Homicide det	inad 200. Fla	ce of Injury - At I Iding, etc. (Spec		treet, factory, office			28f. Location (. City or To	Street and Number wn, State)	or Rura	l Route Number,
Hospi	within 24 hours after To the Funeral Directory completely filled in by	Medical	29a. Certifier 1 Certifyir (Check only one)	Examiner: On the	he best of my kr basis of examin anner stated.	nowledge, dea nation and/or i	ith occurred at the ti nvestigation, in my	me, date a opinion, de	nd place, ath occur	and due to the red at the time,	cause(s) and manr date and place, an	ner as st d due to	ated. the cause(s)
Tothe	within To the comple	Me	29b. Signalure and title of certifie	r	MR	5,	29c. Licen:	se number	94	6	29d. Date signed (Month,	Day, Year)
	541		30. Name and address of person NADIA AKHMED	,	use of death (Ite			POLIS	, MD	21014	/		
*	St Regist	ate	31. Date filed (Month, Day, Year) APR 0 2	3/2	Ponietrar's Sign								

		1	For State Registrar	State of Mar	yland / Depa <i>Cei</i>	artment of F rtificate of	lealth and M <i>Death</i>	lental Hyg R	iene _{eg. No.} 201	04 10108
			Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
	Physicia		DANA	ARNEST				MARCH	I do	04 11:25 AM
	/Medic Examin		4a. Fecility Name (If not institution, give st	reet and number)		4b. City, Town, o	r Location of Death		4c. County of	Deeth
	Examin	Ψ'	Levindale Hebrew G	Seriatric			Baltimore			
	Funeral		5. Social Security Number 6. Sex 1 \square	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 1,	Yeari	9. Birthplace (State or Foreign Country) Illinois
V,	Director	-	Usuel Residence of Decedent							
	land low		10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	Man a-f ah	tor	MD Baltimor	e	Towson					1 ☐ Yes 2 🗖 No
	h the	Director	10e. Street and Number		, ,	10f. Zip Code		1	0g. Citizen of Wh	
	23a c	ai	938 Beaver Bank Ci	rcle		21286			United S	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, I're Medical Examical court be notified at once.	Fur	11. Marital Status 1 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Was Decedent Ev Armed Forces? □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, White, etc. Vhite
8	hour	edt	15. Decedent's Educ		16a. Dece	dent's Usual Occup	pation		16b. Kind of Busi	iness/Industry
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Maryland 21215-0036	Ments Ments arked	2	Robert James Warb				Joanne U			
au	and and le ma	1 4	19a. Informant's Name/Relationship (Typ		1		and Number or Run			
≥, ≤	and ealth m 27 har tr		Mr. Paul Arnest/Hu	usband	938 20b. Place of Dispo		ank Circle		10, MD 21 20c. Location - C	
Baltimore,	Pages 1 ment of H ant: # Ite ury or otl		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		Chesape	matory or other pla ake Crema	ce) tory	Mar 31 2004	Beltsvil	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service License	el	100986	8717 Gre	n and Fun en Pastur	es Drive	e Baltir	es more, MD
4	11,-		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the cause on each line	he death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
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H	/Medical		resulting in death)		consequence of):					1
B	Examiner		Sequentially list conditions, b		Α.					
	sit s	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
)	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
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O. Box (that the death certificate be executed the by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnance Other (specify)	у		23d. Date Mont	of delivery h Day Year
σ.	that t ed by detail		Part II. Other significant conditions con	tributing to death but	not resulting in the t	underlying cause gi	ven in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
ds,	urres sign ld be	d by	METASTATIC BREA	ST CANC	ER			1 □ Y	es 2□No 3	3 ☐ Probably 4 ☑ Unknown
of Vital Record	The law requires that the rate has been signed by the page 2 should be detached.	Completed						24a. Was a autop perfor	med? de	ere autopsy findings available ior to completion of cause of sath? Yes 2 No
tal		a)	25. Was case referred to medical				26. Place of Dear			
>	Physiclan: this certific	To B	examiner? 1 Yes 2 No	lospital: 1 Inpatien	t 2 ER/Outpatie	ent 3 DOA Ot	her: 4 Nursing H	ome 5 Resid	ence 6 Other	r (Specify)
	g Phys er this neral di		27. Manner of Death	28a. Date of Injury (Month, Day	Year) 28b. Time (of 28c. Inju	ry at ork?	28d. Describe h	ow injury occurred	d
io	Attandin death. ctor: Aft y the fur	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation			M 1	Yes 2 No			
Division	al or Atta s after de il Directo	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injui building, etc.	ry - At home, farm, s (Specify)	treet, factory, office		28f. Location (S City or Tow	Street and Number m, State)	r or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Physical Control 2 Medical Examination	sician: To the best of ner: On the basis of and manner stat	examination and/or it	ath occurred at the t nvestigation, in my	ime, date and place, opinion, death occur	and due to the orred at the time, or	cause(s) and man date and place, an	ner as stated. nd due to the cause(s)
	Cothin within Fothin complex	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed	(Month, Day, Year)
	- > - 0		Donna m. &	unley	mo	D5	14739	Swogray	MARCH	29th 2004
	1		30. Name and address of person who co		_	h Print)	marq	land	21215	- 3 /
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registra 2 2004			5	1 ()		
				1000	man and the	Ber Ber Barre				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

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Reg. No.	Chapte			7		U	Ĭ	U	4

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		_	Decedent's Name (Fi		PER INF G	530 4/0//0	4 111			2.	Date of Death Month		Yeer	3. Time	of Death
	Physicia /Medic	al			eth Bel	1					MARCH	27	, 2004		34 A ^M
	Examin	er	4a. Facility Name (If not UNTVERSITY					y, Town, oi ALTIM	Location of	of Death CITY		40.0	County of Deet	n	
	Funeral		5. Social Security Numb			e (In yrs. last birt	hday) If Und	ler 1 Year	If Under Hours		Date of Birth (Month, Day,	Vear		nplace (State untry)	or Foreign
	Director		219-32-77	129]M 23K2]F	70	rs. Month	s Days	Hours	Ap	ril 9	, 1	933 ઁ	MD	
	and w		Usuel Residence of Dec 10a. State 10	b. County		10c. City, Town	or Location							10d. Inside	City Limits
	Maryl -1 sho	ţŏ	MD	N/A		Balti	more							1 X)Y	s 2 No
	or 28a	Director	10e. Street and Number				10f.	Zip Code			10	g. Citiz	en of What Co	untry?	
	23a c	raiD	5200 Keni	lworth				2121					S.A.		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland lat Hygiene. dother than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event. I'm Medical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4 ☐		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	10	1 ☐ Yes	2 ½ No	Specify:		Yes or No- an, etc.)	1	4. Race - Ame Black, White Specify: B1	e, etc.	
S C	72 hc natu	etec	15. (Specify o	. Decedent's Edu only highest grad	cation e co <i>mpleted)</i>	16a.	Decedent's U (Give kind of life. DO NO?	work done	ation during mos	t of working			I TOPE	-	
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9	I Hygid other	BeC	17. Father's Name (Firs	st, Middle, Last)					18. Mothe	er's Name (F	irst, Middle, N	faiden S	Sumame)		
la	should be ind Mental marked o	ToE	Isaac Ba	gwell							Carso				
lan.	2 sho and is m		19a. Informant's Name										Town, State, 2		744
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altimore,	permit. Pages Department of t Important: If Its any injury or or pace.			remation 3 F		Garris Vetera	ans Ce	mete	ry 🗎	/2/04	0	win	ngs Mi al Wo	11s,	
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### ARTICLAM BARNES ### CATON MANOR NIRES INC HONE ### AND PACE OF THE PACE			1 - For Amend Item # Registrar 1. Decedent's Name (First, Middle, Lasi					2. Date of D	eath	1,011,000	3. Time of Death
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3. Social Security Numbers 1.			4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Dea	th	40	. County of Deel	th
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Part Continued		Se C	17. Father's Name (First, Middle, Last)				18. Mother's Na	ime (First, Middle	e, Maider	Sumame)	
ALMETRIC D. BARNES (WIFE) 20a. Method of Disposition Widewind 2 Coregoration 3 Removal from State Coregoration Core			MEADY BARNES				LILLIE	DAVIS			
20b. Method of Disposition Comment Comme	ĺ		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mail	ing Address (Stree	t and Number or R				
CEDAR HILL CEMETERY APR	l			S (WIFE)		the state of the s	H AVENUE				
22. Name and Address of Facility LOUDON PARK FUNRAL HOME BAITINGRE, MARYLAND 21229 23a. Debt Enter the desease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest. Immidate Cause (Final federal Between Onset and Death Control of Cause or Onset and Death Control of Cause of Cause (Final death Control of Cause of Cause (Final death Control of Cause of Cause of Cause (Final death Control of Cause of Ca	١		1XO Burial 2 ☐ Cremeation 3 ☐	Removal from State	cemetery, cre	matory or other pla	AFK	. 1,			
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25. Was case referred to medical examiner? 1		eted						11			
25. Was case referred to medical examiner? 1	•	E E						auto	opsy	prior to death?	completion of cause of
examiner? Yes 2 No			de Montre de madre de la constant					1 ☐ Yes	2 D N	o 1 ☐ Yes	2 12 No
27. Manner of Death 1 Natural 2 ∩ Accident 3 ∩ Suicide 4 ∩ Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M Work? 1 ∩ Yes 2 ∩ No 28c. Injury at Work? 1 ∩ Yes 2 ∩ No 28d. Describe how injury occurred 2		8	examiner?	Hospital:	1 2 □ EB/Outpate	at 20 ma 0	han 1			6 DOther (Con	
2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 29a. Certifier (Cheek only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)				28a. Date of Injury	28b. Time						city)
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			William Attio	Moins bh	45 icram	DO	3/42		Mr	/	4 -
X/ACIHOU 561/ HOCKROWN Blvd 303 FC/7/m/2021239			, DAMA L	11	/	NI	- 0 0		100		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** R.DSA.M Month 2004 Louise May Bibeault /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner BUNIE par If Under 24 Hrs. GIEN B Hrunde NORTH HRUNDEL HOSPITAL 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min 1 M 200 F 83 Vrs 578-12-5025 Director Washington, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show 10a. State 1 ☐ Yes 2 📉 No Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with I and of Health and Mental Hygiene.
anent of Health and Mental Hygiene.
anent if Hem 27 is marked other than "natural", or itams 23a or "
ury or other traumatic event, the Musical Examinational Lea 635 Baylor Road 21061 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∏Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell Owen Leigh Emma May Clementson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health as Important: If Item 27 is any injury or other traugonce. Mr. Thomas P. Bibeault / Son 125 Elm Drive Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition April 1, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD * 4 ☐ Donation 5 ☐ Qther (Specify) Maryland Veterans 2004 21. Signatura of Funeral San ice Licensee 22. Name and Address of Facility Singleton Funeral Home PA 1 Second Ave S.W. Glen Burnie, MD 21061 M01220 Approximate Interval Between Onset and Death rant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical to (or as a consequence of): Examiner mone Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to to, as a consequence of Examine use as the burial-tran that initiated events resulting in death) Last the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 Who
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funerel Director: in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760. of Vital Records,

or Attending Physicien:

Hospital

To the h

death.

filled

completely

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

the

Baltimore, Maryland 21215-0036

Division

State Registrar

3

31. Daje filed (Month, Day, Year) APR 02 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

and manner stated

in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

			1 - For Amend Item #19	State of M a-b per	laryland / Der ئے 10 G830	partment of F 2,04 tas ertificate of	lealth and Me Death	ental Hygier	ne 2004	10112
		12	Decedent's Name (First, Middle, Last)				1	2. Date of Death Month	Day Year	3. Time of Death
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	Examin		4a. Fecility Name (If not institution, give s	reet and number	r)	4b. City, Town, o	r Location of Death		4c. County of Death	
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н	Funeral		5. Social Security Number 6. Sex	M 2□F /.A	ge (In yrs. last birthda CA Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, Yea	ar) Cou	place (State or Foreign Intry)
	Director		216-36-5161 X Usual Residence of Decedent		64			11-22-3	9 I M	d
	yland		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	a-f-s	ctor	Md. NA		Bal	timore				1 X Yes 2 No
	or 28	Director	10e. Street and Number	a.		10f. Zip Code		10g.	Citizen of What Cou	intry?
	ath w		201 N. Washingto		Apt.902	2120		4 V N-	USA	issa Indian
36	72 hours after death with the Maryland naturel; or Items 23s or 28s-f show Jical Examiner count be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Deceder Armed Forces 1 ☐ Yes 27 If Yes, Give Year or Dates 	5?]No	If Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ry Yes or No- can, etc.)	14. Race - Ameri Black, White	
9	"naturel"		15. Decedent's Educ			edent's Usual Occup		16b	Kind of Business/Ir	
215		pie	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4o	life	ve kind of work done . DO NOT use retired	during most of working d)	7		
21215-0036	773 Ton See 1888	Completed	9th grade			oorer			Varies	
Maryland		Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maid		
y la	d 2 should be th and Mental 7 is marked c traumatic eve	2	William		Brady	iting Address /Street	Hazel	Pauta Numbar Cit	Smith	n Code)
Mai	7 F N 2		19a Informant's Name/Relationship (Tyr. Michele Tillman-));	üghter	-in-law 4	309 Barbai 53 Lincolr	and Number or Rutal.	altimore,	MD 21206	
	s 1 and 2 f Health Item 27 I		Catherine Brady 20a. Method of Disposition	SISCEL	20b. Place of Dis	position (Name of	Da	Burnie, te 20c.	Md. 210 Location - City or T	**
Baltimore,	0 - =		1 Burial 2 □ Cremation 3 □Re 1 □ Donation 5 □ Other (Specify)	moval from Stat	Woodlar	rematory`or other plac wwwCom	4-3 - 0	M R	altimore,	МА
Ħ	그 든 원 중	1	21. Signature of Funeral Service License	9		22. Name and Addre	CONTRACTOR OF THE PARTY OF THE	Baltimor		1202
ä	Departing Department Important in series in once.		& lading	Warne	S	March F.I	H. East		North Ave	
-40			23a. Pert1. Enter the disease, or complice shock, or heart failure. List only on	ations that caus	ed the death. Do not e	inter the mode of dyir	ng, such as cardiac or			Approximate Interval Between
	Physician	8 (Immediate Cause (Final disease or condition		muestive	Heurt	failure			Onset and Death
	/Medical		resulting in death)		s a consequence of):					
	Examiner		Sequentially list conditions, b							
	₹ ₹	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequence of):					
2	be executed sician and burial-transit	Examine	that initiated events c. resulting in death) Last	Due to (or a	is a consequence of):					
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687	ficate physics the l	edlo	0							
Вох	The law requires that the death certificate be the has been signed by the attending physicial age 2 should be detached for use as the bur	Physician/Medical	23b. was decedent pregnant	lc. If yes, outcom		B Ectopic pregnancy	,		23d. Date of deliv	,
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P.O	that the de led by the a detached	hys	9 Unknown		-					
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alF								1 Yes 2 2		2 No
V:E	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	4 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	innt 30 DOA Oth	26. Place of Death (a Elou (a	
of	Phys rrthis aral di	. To	27. Manner of Death	28a. Date of In	tient 2 ER/Outpati	of 28c. Injur	4 Nursing Hom	d. Describe how in	6 ☐Other (Speci njury occurred	<i>ty)</i>
lon	Attending I ir death. sctor: After by the funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, E	Day Year) Injun		k? Yes 2 □ No			
Division	or Attendi after death. Director: A	ifice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of I	njury - At home, farm, etc. (Specify)	street, factory, office	28	f. Location (Street City or Town, St.	and Number or Rur	al Route Number,
Ö	tal or A	Certification:		Dollowing,						
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	ician: To the be er: On the basis and manner	st of my knowledge, de of examination and/or stated.	ath occurred at the tir investigation, in my o	me, date and place, an pinion, death occurred	d due to the cause I at the time, date a	o(s) and manner as s and place, and due t	stated. to the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier			29c. Licens			Date signed (Month,	Day, Year)
•			Mayons			0 30	377	3	131104	
	2		30. Name and address of person who co				1176 .1.1-	Wan I =	11.10	
			Pobert M. Coop. 31. Date filed (Month, Day, Year)		6503 PA	RK HEIG	itis AVE	BALT	prito 2	1215
	Sta Regist		APR 0 2 2004	A	wa B	Som to				
			MIN V N 2004			1-1				

4b. City, Town, or Location of Death

Baltimore

 a^{M}

1115

2004

NA

4c. County of Death

March

1 - For State Registrar	State of Maryland / Department of Health and I Certificate of Death	Mental Hygiene 200 L	10113
Decedent's Name (First, Middle, Last)		Date of Death Month Day Year	3. Time of Death

Beard

Physician /Medical Examiner

Karen

4a. Facility Name (If not institution, give street and number)

306 E. 20th Street Apt 1

Funer Direct		1	. Social Security 217–82–1		1 M 2 X F	40	Yrs.	Month		urs Min.	(Month, Da	y, Year)	Co	inplace (State of Po ountry)	oreign
P .		-	Isual Residence 0a. State	of Decedent 10b. County		10c C	ity, Town or I	ocation						10d. Inside City L	imits
Aarylan Fehow	ō		Md.	NA		100.01		timor	re					Y Yes 2	
death with the Maryland me 23a or 28a-f ehow rmust be notified at	Direct	1	0e. Street and N		eet Apt.	1		10f. 2	Zip Code	•		10g. Citizer	n of What Co	ountry?	
ē 2 2	by Funeral Director	1	1. Marital Status	mied 2 Married	12. Was Dec Armed Fo 1 Yes If Yes, Gr	edent Ever in U proes? 2 🔀 No ve	J.S. 13		sedent of Hispani pecify Cuban, Me		ocify Yes or No Rican, etc.)		Race - Ame Black, Whit		
Mail fighting 2.1.2.1.2.00000000000000000000000000000	d be	H	3 Midowed	4 Divorced	Year or D	ates:	16a Dec	edent's Us	sual Occupation				of Business		
n n	Completed	-	(Spe	cify only highest g	rade completed) College (1.4or 5.)	(Giv	e kind of v	vork done during use retired)	most of worki	ng				
and 2 should be filed within leath and Mental Hygiene. m 27 Is marked other then her fraumatic event.	E O		12th gr		College (1-401 34)	Но	useke	eping			Loyal	lo Nor	edame	
al Hy	Be (1		(First, Middle, Las	st)					Mother's Name	(First, Middle		_		
Ment Ment Arke	2		UNKN							hirley			Beard		
s 1 and 2 should if Health and Men Item 27 Is marke other traumatic				Name/Relationship					ss (Street and N					Zip Code)	
permit. Pages 1 and Department of Health mportant: If Item 27 invision or other times in violary or other times.		16-	Ernest C		Uncle	20h	200 Place of Disp		one St.,	-	nore, Mo		1218	Town, State	_
permit. Pages 1 and Department of Healt Important: If Item 2'		2	1X Burial	Cremation 3		State	cemetery, cr	ematory o	r other place)	l I					
rtant		-		5 Other (Spec			King M		Pk. and Address of F	4-2-0				own, Md.	_
Depa Impo	Duce	1	21. Signature of F	Uneral Service Lic	o Wa	لـــمى			i F.H. E		Ba.	ltimor	ce, Ma	ryland 2	2120
			23a. Part1. Enter	the disease, or co	mplications that of	caused the dea							i Ave.	Approximate Interval Betwee	en.
Physicia	an		Immediate Cause	(Final	127.55	ustive 1	an A	C. I.	11.0					Onset and Dear	ith
/Medic	al		disease or condit resulting in death)		or as a conse		Touch	rve.						
Examin	er	1	Poguantially list o	anditions	h										
D ==	ne -	1	Sequentially list of Larry, reading to cause. Enter Und	derlying	Due to	(or as a sones	queries of):								
ocuted nd transi	Examiner	- 1	nat initiated even	ty, leading to immediate See. Enter Underlying see (Disease or injury initiated events c.											
cate be executed physician and sthe burial-transit			esulting in death	c											
ate b	lca				d										
th certificate be executed tending physician and ir use as the burial-transi	eted by Physician/Medical	1	F FEMALE:		23c If yes ou	tcome of pregn	ancy								dii ee
ath itter	lan	1	23b. Was deceded in the past 1	2 months?	1 Live t	ointh 2 Fet	al death 3		pregnancy specify)			230	I. Date of del Month	Day Year	r
y the de	yslo		1 ☐ Yes 2 9 🔀 Unknow		9□ Unkn		ueam 5	□ Ottiel (specify						
requires that the de een signed by the a hould be detached f	y P	F	Part II. Other sign	ificant conditions	contributing to d	eath but not re	sulting in the	underlying	cause given in f	Part I.	23e. Did t	obacco use	contribute to	the cause of death	h?
luires n sign	Q D	١.	0	besity,	diabete	is mel	utus				10	Yes 2 K	No 3⊟Pr	robabiy 4 🗆 Unkr	nown
3 00				4 /							24a. Was	an 2	24b. Were au	utopsy findings avai	ilable
ician: The law certificate has b	Сотр	1									autop	osy ormed?	prior to death?	completion of cause	e of
	ပိ	1	25. Was case refe	erred to medical	-				26.1	Place of Death	1 Yes		1 L Yes	2 □ No	
ysician: Is certific director.	To B		examiner?	□No	Hospital:	Inpatient 2	ER/Outpati	ent 3 🗆 I					Other (Spe	cify) at sce	no
t the		1	7. Manner of De	ath		of Injury oth, Day Year)	28b. Time Injury	of	28c. Injury at Work?		28d. Describe I			at sce	110
ottending I death. ctor: After	atlo	1	1 Natural 2 Accident	5 Pending investigat		in, Day Tear,	Interv	М	1 🗆 Yes	2 🗆 No					
To the Hospital or Attenwithin 24 hours after deat To the Funeral Director:	Certification:	ı	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	289. Place	of Injury - At h	nome, farm, s	treet, fact	ory, office	2	28f. Location (lumber or Ru	ural Route Number,	
rs aft al Di	Cer	1								1					
To the Hospital or At within 24 hours after or To the Funeral Directomoletaly filled in by	edical		29a. Certifier (Check only		Physician: To the barniner: On the b	asis of examin									
To the F within 24 To the F	Med		one)		and man	iner stated.			9c. License num					h, Day, Year)	
No T	-	1	29b. Signature an	d title of certifier	U	4	110	-	OCME	1001		March	29 20	504	
. (So	sha 1	Token	ben.	MD								
4				dress of per who	4	se of de (Ite	m 23a) (Typi		11 De	Charal		imara	Ma	land 2120	١1
	State		1 OSha 31. Date filed (Mo		ndera Oz. F	ຼິ⊆ຸ່ນ Registrar's Sign	ature	Ŧ	TT Levu	street	, Balt:	шюге,	mary.	land 2120) T
Reg	State istrar		on Date med (me	APR 1	2 2004)	10	An	and a						
HMH 17 Rev	-0.19			AL IV U	~ LUUT '	M. D. P. S. S. S. S. S. S.	1 - 151	1	-						

2194		State of Ma State Unipend Item#23a,27,PerME,G830 Registrar	ryland / Depa	rtment of Health and N	lental Hygie	ne 2001. 10111
		State Unificati TCHI#224,27,1 CHI 11,000 Registrar 1. Decedent's Name (First, Middle, Last)	o,4/2//Orcer	tificate of Death	Reg.	No. UU 4 U 4
Physicia		Keith Alan Brown			MARCH 3	0, 2004 0924 A M
/Medic Examin	_	4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Deeth n/a
Funeral Director		215-48-9107 ★ M 2□ F 48	(In yrs. last birthday) Yrs.	If Under 1 Year ff Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Ye April 20,	9. Birthplece (State or Foreign Country) 1955 Maryland
Maryland f ehow	lor	Usual Residence of Decedent 10a. State 10b. County Md. Harford	10c. City, Town or Loc Abing			10d. fnside City Limits 1 ☐ Yes 2 전 No
h the l	irect	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
23a c	alD	654 Milford Court		21009		United States
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene are acceptant of the Azis marked other than "natural", or items 23s or 28s-1 show any injury or other trsumatic avent, it a Medical Examinar must be rediffed at angles.	by Funeral Director	11. Maritaf Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes, Give Year or Dates:	0	Vas Decedent of Hispanic Origin? (Sp i Yes, specify Cuban, Mexican, Puerto I ☐ Yes 2☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036 sol within 72 hours at giene. or than "natural", or or than Medical Exert.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	(Give	lent's Usual Occupation kind of work done during most of work DO NOT use retired)	ting 16b	o. Kind of Business/Industry
d 212 filed withi Hygiene. ott, the		12 years 17. Father's Name (First, Middle, Last)	eleva	ator constructor	e (First, Middle, Maid	elevator
yland ould be fi Mental H narkad ott	To Be	Howard L. Brown, Jr.		Mary A.	•	our our array
Maryland of 2 should be file lith and Mental Hy 27 is marked oth	-	19a. Informant's Name/Relationship (Type, Print) Patricia A. Fitting/lifema		g Address (Street and Number or Run Milford Court, A		
Baltimore, permit. Pages 1 ar Department of Hea mportant: If item any injury or other ance.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☒ Other (Specify) mausoleum		sition (Name of natory or other place) Mem. Gdns. 4/3		Location - City or Town, State
Baltimore, Mispermit. Pages 1 and 2 Department of Health a Important: If item 27 item 27 item 27 item 2005.		21. Signature of Funeral Service Licensee	22	Home of E	Bel Air, Inc. Air, Md. 21014	
Physician /Medical Examiner bhysician and bhysician and the prival-Itansii the prival-Itansii	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):			
BOX 687 death certificate e attending phys ed for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[\text{Yes} \ 2 \] No 9 \[\text{Unknown} \] Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of defivery Month Day Year
cords, P.O. v requires that the been signed by the should be detached.	by	Part II. Other significant conditions contributing to death but	it not resulting in the ur	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
I Rec The law ate has b	Completed				24a. Was an autopsy performed	
of Vital F Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 XYes 2 No Hospitaf: 1 Inpatier	nt 2□ER/Outpatien	Othors	th (Check only one)	e 6 □Other (Specify)
on ting	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injur (Month, Day		The same of the sa	28d. Describe how i	
Divisio	Certification;	3 Suicide 6 Could not be determined 28e. Place of fnju building, etc	ry - At home, farm, str . (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, late)
To the Hospitet within 24 hours a To tha Funeral I completely filled	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Exeminer: On the basis of and manner sta	examination and/or in-	n occurred at the time, date and place vestigation, in my opinion, death occur	and due to the causi red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within 2 To tha comple	Me	29b. Signature and title of certifier M. M. T.		29c. License number OCME	_	Date signed (Month, Day, Year) MARCH 31, 2004
		30. Name and address of person who completed cause of de	111 Per	on Street. Baltimo	ore, Maryl	and 21201
Sta Regist		31. Date filed (Month, Day, Year) APR 0 2 2004 Registra	r's Signature	all I	_	

ADH DAVID BENNETT 04 - 2126

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 4 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 1230 P M MARCH 27. Bennett David 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 3 N. KOSSUTH STREET BALTIMORE CITY If Under 1 Year | If Under 24 Hrs.
Months Days | Hours | Min. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 11€ M 2 ☐ F 1945 North Carolina 58 Director 216-42-3671 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County il Hygiene. Jother than "natural", or Items 23e or 28e-1 envi-rvent, tra Medical Examinar must be coulded at 1√2 Yes 2 □ No Director Baltimore Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21229 3 N Kossuth Street by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: B1ack 3 ☐ Widowed 4 🕅 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Driller Robert B. Balter . Pages 1 and 2 should be filed w trnent of Health and Mental Hygier tant: If item 27 is markad other th jury or other traumatic event, ILs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elouise Bennett John C. Saxton ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 02482 5 Pine Tree Road Wellesley, MA Wendy Gipson Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Apr 1, 2004 Hampstead, MD Carroll Cremation * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 fue W 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CArdicular Disease HTHERUSCLEGATE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and physician an is the burial-tr Due to (or as a consequence of): Box 68760 Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No o. the 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 🗆 No To the Hospital or Attending Physician: 26. Place of Death Check onl one 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 MOther (Specify) AT SCENE Yes 2□No 2 ER/Outpatient 3□ DOA Certification: To this 27. Manuer of Death 1 Natural 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Diractor: in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME MARCH 28, 2004 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person with 111 Penn Street, Baltimore, Maryland 21201 JACK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 2 2004

Registrar

1		artment of Health and Mental Hy	2001 1011
	1 - State Registrer AMEND ITEM#5 PER FH G830 4/02/04 JHCe. 1. Decedent's Name (First, Middle, Last)	2. Oate of D	Reg. No. 2 3. Time of Death
Physician	William E. Clarke	Month MARCH	Day Yeer
/Medical Examiner	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Deeth	4c. County of Death
Cxamille	600 Blk N. MILTON AVE	BALTIMORE CITY	N/A
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of B Months Days Hours Min. (Month, D	
Director	Usual Residence of Decedent	April 2	25,1979 NY
dand ow	10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
the Marylan 28a-f show mulfired at	MD N/A Balti	mone	1 ☑ Yes 2 ☐ No
or 28a	10e, Street and Number	10f. Zip Code	10g. Citizen of What Country?
Site that the Mark tier than 23e or 28e-f all rifes must be multipled from the formal free from the formal free from Function from Function from the formal free free free free free free free fre	127 N. Bond Street	21231	054
ltema Inerma	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
J36 Jr. or aft	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 21 ☐ No Specify:	Specify: 3 /ack
5-0036 72 hours after death with the Maryland natural; or Itema 23a or 28a-f ahow odeal Examiner must be netified at leted by Funeral Director	15. Decedent's Education 16a. Dece	adent's Usual Occupation a kind of work done during most of working	16b. Kind of Business/Industry
within 7 within 7 ane. Then "n Item "n Item and	(Specify only highest grade completed) (Give life.	DO NOT use retired)	Construction
nd 21215-00 e filed within 72 hou al Hygiene. I other than "naturu vant, the Medical B	1/25	18. Mother's Name (First, Middle	
and libe fill hotal H ed out	17. Father's Name (First, Middle, Last) Stanley Clarke,	Gilda Pri	
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-f ahoo other traumatic avant, the Medical Exertired must be nutified at To Be Completed by Funeral Director		ling Address (Street and Number or Rural Route Num	
Ma nd 2 s uith an 27 is r trau	Lisa Houston Sister 12	7 N. Bond Street	Baltomore, MD 21231
re, Ma	20a. Method of Disposition 20b. Place of Disposition	position (Name of Date	20c. Location - City or Town, State
Baltimore, permit Pages 1 a Department of Hee Important: If Item any injury or othe ones.	1 Deural 2 Micromation 3 Hemoval from State 4 Donation 5 Other (Specify)	ew Crematory 7-6-04	Baltimore MD
Balti permit. Departr Importa any inju	21. Signature of Funeral Service Licenarie	22. Name and Address of Facility Funeral	Service, P.A.
m gora	T	709 Tessier St. Be	aftemore MD 21201
	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on paoh line.	iter the mode of dying, such as cardiac or respiratory	Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	Nouse of Head	
Examiner	Due to (or as a consequence of):		
je e e e e e e e e e e e e e e e e e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		
executed in and ial-transit	that initiated events c.		
760, le be executed ysician and e burial-transit	resulting in death) Last Due to (or as a consequence of):		
8760, cate be exphysician the buria	d		
P.O. Box 68 nat the death certifica by the attending pt letached for use as the physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
Bcath death atter of for u	23b. Was december pregnant in the past 12 months? 1 Yes 2 No	☐ Ectopic pregnancy ☐ Other (specify)	Month Day Year
P.O.	9 Unknown		
S, Fres tha		and only in grant and a second	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Records, The law requires t te has been signe age 2 should be o			7
Il Record The law requirate has been s page 2 should Completed		24a. Wa aut	as an 24b. Were autopsy findings available prior to completion of cause of death?
al Re In: The Incate har r, page		1 Yes	2 No 1 Types 2 No
Vital reicien: T s certificate birector, pa		26. Place of Death (Check only	sidence 6 MOther (Specify) SCENE
Physerthis eralds	CO. Deterflaine		e how injury occurred
ion inding lath.	1 Natural 5 Pending 2 Accident investigation 3 30 9 4 (93)	7 M 1 Yes 2 No Jak	bject short
Division of tall of Attending P all Director: Alter ed in by the funers Certification;	3 Suicide Homicide 3 Suicide 4 Could not be determined 28e. Place of Injury · At home, farm, so building, etc. (Specify)	street, factory, office 28f. Location City or T	(Street and Number or Rural Route Number, own, Jate)
D sital o		SHEET 600	BIF M. Milton Tre
o the Hosp thin 24 hou the Fune mpletely file Medical	29a. Certifier 1 Certifying Physician: To the bast of my knowledge, dea (Check only one) and manner stated.	ith occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the time	e, date and place, and due to the cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir	29b. Signature and tiple of certifier	29c. License number	29d. Date signed (Month, Day, Year)
F S F O	1 X Loke and	OCME	MARCH 31, 2004
7	30. Name and address of person who completed cause of death (Item 23a) (Type	a, Print)	timono Manuland 21201
	JUAN WIKEND	III remi Street, Ball	timore, Maryland 21201
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	nel	

			For State Registrar	State of I	Marylan		artment of rtificate o				giene Reg. No:	004	10117
	Dhosiai		1. Decedent's Name (First, Middle,	Last)						Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Theodore	A	•	Colic				March	29, 2	004	4:40 A M
	Examin		4a. Fecility Name (If not institution,				4b. City, Town				1	ounty of Deeth	
			Washington Adv				Takom	a Park		B. Date of Birt		tgomer	
	Funeral			5. Sex 7. 1⊠M 2□F	Age (In yrs.) 86	Yrs.	Months Day			02/23/	1918		place (State or Foreign intry)
	Director		186-05-7502 Usual Residence of Decedent		- 00							renr	nsylvania _
	yland		10a. State 10b. County	0 1	1	y, Town or Lo							10d. Inside City Limits
	e Mar	Funeral Director	Maryland Prince	e George's	Ft.	Washi	ngton						1 ☐ Yes ※ No
	or 28	Olre	10e. Street and Number				10f. Zip Code	Э			10g. Citize	n of What Cou	intry?
	ath w	rai	1110 Shago Dri					744		7 7		SA . Race - Amer	ican Indian
	er de Items	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceded Armed Force od 1 X Y es 2	es?	5. 13.	Was Decedent of If Yes, specify C	uban, Mexica	an, Puerto R	ican, etc.)	14	Black, White	
39	ar, or	۵	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date		II	1 ☐ Yes 2XX	lo Specify	γ:		S	pecify:	√hite
21215-0036	2 hou	Completed	15. Decedent'			16a. Dece	dent's Usual Occ	cupation	et of working	0	16b. Kind	of Business/I	ndustry
215	e.	nple	(Specify only highest Elementary/Secondary (0-12)	College (1-4	or 5+)		kind of work do DO NOT use ret		St Gr WORKING	9			_
	ed wi ygien yar th		12			Self	employ		hada Marsa	(First, Middle,			Investing
Maryland	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. In marked other then "netural", or Items 23a or 28a-f ahow marked other then "netural", or Items 25a or 28a-f ahow unatic event, Ite Medical Examinat must be notilled at	To Be	17. Father's Name (First, Middle, L Angelo Colico							crease	Malden St	umame)	
چ	d Mei d Mei marke	မှ	19a. Informant's Name/Relationsh			19b Mailir	ng Address (Stre				er. City or 1	Town, State, Zi	ip Code)
Σ	and 2 s salth an n 27 is er trau		Gregorine Colid		e		Shago D						
ē,	s 1 ar f Hea ftam 3		20a. Method of Disposition		20b. P		esition (Name of matory or other p		Da			ition - City or T	
e E	Pages nent of int: If it.		MXWirial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		110		ans Cem		04/02/	2004	Chel	tenham,	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23a or 28a-f show any nijury or other traumatic event, Ita Medical Examinat must be notified at once.		21. Signature of Funeral Service L	icensee,		22	2. Name and Ado Ge	or e	· Kal	as Fun	aral,	Home I	A. 20745
# HA	5.		23a. Part1. Enter the disease or of shock, or heart failure. List of	complications had cau	sed the death	n. Do not ent	er the mode of o	tying, such a	s cardiac or	respiratory a	rrest,	880-	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		504	1915							Onset and Death
	/Medical		resulting in death)	Due to (or	as a con leq	uence of):	N	0.0					
	Examiner	L	Sequentially list conditions,	b	Supa	4Cc	Show	h					
	bed Isit	Examiner	Sequentially list conditions, I any, loading to immediate cause. Enter Underlying Cause (Disease or injury	Du6 to (or	. 15 d. U.S. 15 d.)	denica ory							
_6	axecu al-trai	xar	that initiated events resulting in death) Last	c Due to (or	as a conseq	uence of):							
8760,	death certificate be executed e attending physician and of for use as the burial-transit			d									
9	tificat ig phy as th	Physician/Medical											
Вох	leath certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		Ectopic pregna	псу			23	d. Date of delin	very Day Year
O. B	the att	sici	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregn <i>a</i> r 9□ Unknow	it at time of d	eath 5	Other (specify)					MOHEN	Day 18a1
<u>G</u>	30 of		Part II. Other significant condition	se contributing to deat	th hut not res	ulting id the u	nderlying cause	given in Part	H	23a Did t	obacco use	contribute to	the cause of death?
ds,		1 by	End St	Se rer	20 i	NIL	2850	/ 0	MI	10	Yes 2□	No 3∏Pro	bably Aunknown
Sor	law requires as been sign 2 should be	etec	Covi	3		<u> </u>				24a. Was	an	24h Ware aut	onsy findings available
Vital Records,	e la has	Completed	001	<u> </u>						autop	rmegi?	death?	opsy findings available ompletion of cause of
ta	ician: Th certificate rector, pag	e C	25. Was case referred to medical					26 Plac	ce of Death	1 ☐ Yes (Check only o	250 No	1 🗆 Yes	2 No
>		O B	examiner? 1 ☐ Yes 2 No	Hospital:	atient 2	ER/Outpatier	nt 3 DOA	Other				□Other (Spec	ify)
n of	ding Phys	n: T	27. Mather of Death 1 Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury	f 28c. Ir	jury at Vork?	28	8d. Describe I	how injury	occurred	
Sio	Attending ir death. ector: After by the fune	catle	2 Accident investig	ation				Yes 2					
Division	al or Att	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 280. Flace of	f Injury - At ho , etc. (Specif	ome, farm, str	reet, factory, offic	Ce	28	Bt. Location () City or Tol		Number or Rui	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (Physician: To the b xaminer: On the bas and manne	is of examina								
	To the within 2 To the complet	Me	29b. Signature and title of certific	01/8	9-		29c. Lig	nse number	511	21	29d. Date	sidned (Month	Day, Year)
	27		100	1			200	V4	37	71	0	129	114
_	للو		30. Name and address of person v	NEGI	STIE	2	Print) Wis	shing	rton	Ad	vent	st h	1051
	Sta Regist		31. Date filed (Month, Day, Year) APR 0.2 200		istrar's Signa نمستر	iture Li	log de	ar.					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** 257AM MARCH 2004 Mark Frederick Creel /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecitity Name (If not institution, give street end number) Examiner Havre de Grace Harford 3816 Moxley Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) | 07/20/1955 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months 1 M M 2□ F Maryland Director 216-78-0284 48 Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health end Mentel Hygiene. Int: If Item 27 is marked other than "nature!, or items 23s or 28s-? show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2X No Funeral Director Havre de Grace Harford MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 3816 Moxley Road 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0020 Specify: þ White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Carpenter 2 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Virginia Collison 2 Paul Frederick Creel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3816 Moxley Rd., Havre de Grace, MD 21078 Peggy Ann Creel- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or Meadowridge Mem. Park 3/27/04 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Mitchell-Smith Funeral Home, P.A. 21. Signature of Funeral Service Licensee 123 S. Washington, Havre de Grace, MD 21078 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, snock, or heart failure. List only one cause on each line. Physician Immediate Cause (Finat disease or condition resulting in death) /Medical Examiner Examiner Core buriel-transit Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 KNO 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death To the Hospital or Attending Pt within 24 hours efter death.
To the Funeral Director: After th completely filled in by the funera 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier completed cause of death (Item 23a) (Type, Print) HOLADIRO AVE BALTO NY ZIZZZ 32. Registrer's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryland	Department of Health a Certificate of Death	-	ene g. No.2004 10119
	Physici		Decedent's Name (First, Middle, Last Cochard	P Cook		2. Date of Death Month March	Day Year 3. Time of Death
}	/Medic Examir		4a. Facility Name (If not institution, give	- 11 /	4b. City, Town, or Location of Have de 6		4c. County of Death
	Funeral Director		5. Social Security Number 6. Se				Year) 9. Birthplece (State or Foreign Country)
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location		10d. Inside City Limits
	r 28a-f sl	irector	MD Harford 10e. Street and Number	Hav	re de Grace	10	g. Citizen of What Country?
	death with	Funeral Director	620 North Adams	12. Was Decedent Ever in U.S.	21078 13. Was Decedent of Hispanic Ori	gin? (Specify Yes or No-	USA 14. Race - American Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than *natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinat riust be multiled at Ance.	þ	1 X Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican 1 ☐ Yes 2 ▼ No Specify:	ř, Puérto Rican, etc.)	Black, White, etc. Specify: White
21215-0036	hin 72 ho an *natur Medical	Completed	15, Decedent's Edu (Specify only highest grad		Decedent's Usual Occupation (Give kind of work done during mos. life. DO NDT use retired)	t of working	6b. Kind of Business/Industry
d 21;	a filed with Hygiene other the vent, the	Be Com	5th 17. Father's Name (First, Middle, Last)		Bottle Washer 18. Mothe	or's Name (First, Middle, Ma	Pepsi Cola Company aiden Sumame)
Maryland	ould by Ments	ToE	Nicholas P. Cook	una Orinti	Adla 19b. Mailing Address (Street and Number	aide Wilson	City of Town Code To Code
	alth and 2 st		Janet Dill- Cousin	- N	05 Northway, Hav		
ore,	ges 1 and or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State cerns	e of Disposition (Name of etery, crematory or other place)		Oc. Location - City or Town, State
Baltimore,	mit. Pa partmer portant: r injury		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		I Hill Cemetery 0	3/29/04 H	avre de Grace, MD
ä	E Per Contraction of the contrac		Chilama v	J. Dringe) 1123 S. Wasningt	on, Havre d	e Grace, MD 210/8
	Physician /Medical		23a. Part 1. Enter the disease, or comp snock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.		Failufe	st, Approximate Interval Between Onset and Death
	Examiner	ı.	Sequentially list conditions. if any, leading to immediate	b			
	ecuted and -transit	Examiner	Cause (Disease or injury	c. Due to (or as a consequent			
8760,	icate be executed physician and s the burial-transit			d.	CG 01).		
P.O. Box 6	death certif e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
	The law requires that the de ate has been signed by the a page 2 should be detached	by	Part II. Other significant conditions co	ntributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to the cause of death?
Division of Vital Records,	as s	Completed				24a. Was an autopsy performe	
ital	iician: Th certificate rector, pag	Be Co	25. Was case referred to medical examiner?		26. Place	of Death (Check only one)	ĬNo 1 ☐ Yes 2 ☐ No
ot <	Physician: r this certifica ral director, p	ဥ	1 ☐ Yes 2 ☑ No	and the same of th	Outpatient 3 DOA Other: 4 Nu b. Time of 28c. Injury at	rsing Home 5 🗆 Residen 28d. Describe how	
ion	Attanding I r death. actor: After by the funer	ation	1 ■Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury Work? M 1 Yes 2 1		Thirty occurred
Divis	i te	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospital within 24 hours a To the Funeral Completely filled	edical (29a, Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowler iner: On the basis of examination and manner stated.	dge, death occurred at the time, date an and/or investigation, in my opinion, dea	d place, and due to the cau th occurred at the time, date	ise(s) and manner as stated. e and place, and due to the cause(s)
	To th within To th	M	29b. Signature and title of certifier Leel	1 4.p	29c. License number	904	d. Date signed (Month, Day, Year) ろ/ユケータ
	5		30. Name and address of person who co	ompleted cause of death (Item 23	a) (Type, Print) Duran Avenue	Hame de	Grace Up 21078
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature			

Cook, Richard &

			1- For Amend Item	State of Ma #15,16a,22	per i	I / Depa th C83	utment of tificate o	Health a Las f Death	and Me	ental Hyg	giene Reg. No.	2004	10120
			Decedent's Name (First, Middle							2. Date of Dea			3. Time of Death
	Physicia /Medic		Georgia M. (Coronado						March		2004	11:10 AM
į	Examin		4e. Fecility Name (If not institution	, give street and number)			4b. City, Town	, or Location	of Death		4c. C	ounty of Death	
			48 Landmark					sex				Baltimo	
	Funeral		5. Social Security Number	6. Sex 7. Age		st birthday) Yrs.	If Under 1 Year Months Day		Min.	Month, Da	v, Year)	9. Birth	plece (Stete or Foreign htry)
	Director		220-52-3514 Usual Residence of Decedent		53	113.				Apr 18	, 195	00 Mar	yland
	land ow	Ì	10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Mary if sh	ţō	MD Balt	imore		Es	sex						1 ☐ Yes 2大 No
	h the	Director	10e. Street and Number				10f. Zip Code	9			10g. Citize	n of What Cou	ntry?
	th wit		48 Landmark Co	ourt			2	1221			U	SA	
	ours after death with the Marylan ral', or Items 23a or 28a-f show Exarchent must be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces? 1 ☐ Yes 2 💆	Ever in U.S	13.	Was Decedent of Yes, specify Ci	of Hispanic Ori uban, Mexicar	igin? (Spec n, Puerto Ri	ify Yes or No- ican, etc.)	. 14	 Race - Americ Black, White, 	
30	s afte	by Fu	1 A Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 ☐ Yes 2 🔼 lif Yes, Give Year or Dates:	No		1□Yes 2 X]N	lo Specify:			s	specify: W	hite
3	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show rdical Enandrer must be motified at		15. Deceden			16a. Decec	ient's Usual Occ	cupation		-unk	16b. Kind	d of Business/In	dustry
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717	filed within Hygiene. ther then ent, the Me	mo	Elementary/Secondary (0-12)	unk	0+)	Ca	feteri	Serv	ice		hos	pital	
Maryland 21215-0036	~ - 0 5	Bec	17. Father's Name (First, Middle,	Last)		ou	I C C C I I	18. Mothe	er's Name (First, Middle,	Maiden S	'umame)	
<u>a</u>	should be and Mental marked o	To	Jose Coron	ado					Cami	.11a Br	agg		
a L	and and lis m	W.	19a. Informant's Name/Relations			19b. Mailin	g Address (Stre	et and Numbe	er or Rural i	Route Numbe	r, City or	Town, State, Zip	Code) unk
	of Health litem 27	1	David Paul Co	nado/nepne		4.0	. Was division of						
0			20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from State			sition (Name of natory or other p	olace)	Da	10	20c. Loca	ation - City or To	own, State
altımore,	nit. Pagartment ortant: injury i		*4 □ Donation 5 🖔 Other (S		Mt.	Car	mel Ce	m	$\frac{3}{2}\frac{31}{31}$	/04	Ba	ltimor	e, MD
g	permit. Pag Department Important: I sny injury c		21. Signature of Funeral Service Ronald	Wade, Dire	ector	Şŧ	ate Ana	tomy B	gera.	8717W	Balt	imore Pasture	Alternative
p	Physician		23a. Parti. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition	complications that caused only one cause on each lin	d the death.		er the mode of d		cardiac or			m'as	Approximate Interval Between Onset and Death
н	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):					-		
Н	Z Z	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequi	ence of):							
)	ted nsit	nine	Cause (Disease or injury	6	2 00/15042	51,60 51).							
,	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):							
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Õ	tifical ng ph as th	ledi	15 55 14 1 5				<u>-</u>						
Вох	death certifical attending plates as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at	2 Fetal	death 3	Ectopic pregnal Other (specify)				23	ld. Date of delive Month	ery Day Year
P.O.	that the de led by the a detached t	ysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9☐ Unknown			3 0 (, , , , , , , , , , , , , , , , ,						
Records, P	Se US	by	Part II. Other significant condition Morlaid	ons contributing to death b	out not resu	Iting in the u	Sleck	01.	1009		bacco use		he cause of death?
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æ	The law te has age 2 s	mo							,	autop perfo	rmed?	death?	-
ta	icien: Th certificate rector, pag	Bec	25. Was case referred to medica	1				26. Place	e of Death (Check only o		7,0143	2210
\geq	Physici this cer at direc	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	erit 2 🗆 E	ER/Outpatien	t 3 DOA	Other: 4 No	ursing Home	e 5 Resid	lence 6	Other (Specif	'y)
0	ing Ph J. After th funeral	:uC	27. Manner of Death 1 ☑Natural 5 ☐ Pendir	28a. Date of fnju (Month, Da	ıry ıy Year)	28b. Time of fnjury	28c, in	njury at Vork?	28	d. Describe h	ow injury	occurred	
<u>0</u>	death. ctor: A	catio	2 Accident investi	gation			M 1	☐ Yes 2☐					
Division of Vital	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate h. completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could 4 Homicide determ		jury - At hor lc. <i>(Specify,</i>	me, farm, str	eet, factory, office	се	28	If. Location (S City or Tox	Street and m. State)	Number or Run	al Route Number,
	pitel burs a erel f		29a. Certifier 1 V Certifyin	ng Physician: To the best	of my know	vledge deat	occurred at the	time date ar	nd place, an	nd due to the	called(e) a	nd manner as s	tated
	24 hos 24 hos Fun etely	edical	(Check only 2 Medical one)	Examiner: On the basis o and manner st	of examinati	on and/or in	vestigation, in m	y opinion, dea	ath occurred	at the time,	date and p	lace, and due to	the cause(s)
	To the To the Somple	Me	29b. Signature and title of certifie	ır			29c. Lice	ense number	-			signed (Month,	
			▶ ##	N-D				1-38	15	4	03	-25-	-2004
	3		30. Name and address of person	who completed cause of c	death (Item	23a) (Type,	Print) CAS	TERM	1 1	LVD	_ /	MD	21221.
	Sta Regist		31. Date filed (Month, Day, Year,	2. Registr	rar's Signat	urg	boards	/					

State of Maryland / Department of Health and Mental Hygiene 2004 10121 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CRAPPER WILBERT MARCH 2064 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Howard Columbia 6332 Amherst Ave. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1√2 M 2 □ F 142-28-3502 Yrs. Director 1-23-29 Md. 75 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, it a Medical Examinar must be notified at Y□Yes 2□No Director Columbia Md. Howard 10q. Citizen of What Country? 10e. Street and Number 10f. Zio Code 6332 Amherst Ave. 21046 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Navy 12th grade Military permit. Peges 1 end 2 should be file Department of Heelth and Mental Hy, Important: if Item 27 is marked oths eny injury or other traumatic event, QDGs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Benjamin Crapper Elizabeth Hagans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joetta Bydume Niece 6332 Amherst Ave., Columbia, Md. 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Bunal 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Garrison Forest Vet. Owinas Mills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 1101 E. North Ave. March F.H. East 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC ARRHYTHMIA **Physician** /Medical MYOCARDIAL INFARCT **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner ANEMIA and Division of Vital Records, P.O. Box 68760 the attending physicien ABETES MELLITUS as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? page 2 should be detached for Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 robably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 10 24a. Was an certificate has autopsy 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To After this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Tes 2 No investigation 2 Accident after death the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifie estie March 26, 2004 D0060576 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 N. GREENE STREET BALTIMORE MD 21201 LESCIE BELLOSO 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 0 2 2004 Registrar

		State Registrar	State of Maryla		ficate of		R	eg. No. 20	104	1012
sicia	n	1. Decedent's Name (First, Middle, Las. JEROME	t)		Ç.	HASE	2. Date of Dea Month MARCH	Day	Year	3. Time of Death
edica mine	er ⁴	4a. Fecility Name (If not institution, give	opkins H	ospital I	Baltin		City	4c. County NA		
ral tor		5. Social Security Number 6. Se 212-42-2837	7. Age (In y		f Under 1 Year Ionths Days	If Under 24 Hrs Hours Min		(Year)	9. Birthp Coun Md	lace (State or Fore
		10a. State 10b. County Md. NA	10c.	City, Town or Locat			<u> </u>		1:	0d. Inside City Lim
	ā∣	10e. Street and Number			10f. Zip Code		1	log. Citizen of V	Vhat Coun	itry?
	by Fun	248 Dallas Ct. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 You If Yes, Give Year or Dates:	If Yo	212 s Decedent of H es, specify Cuba Yes 21XNo		Specify Yes or No- to Rican, etc.)	Blac	e - Americ k, White,	etc.
	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		16a. Deceden (Give kin- life. DO	t's Usual Occup d of work done o NOT use retired	ation during most of wo d)	rking	16b. Kind of Bu	isiness/Ind	dustry
	Be	9th grade 17. Father's Name (First, Middle, Last)	0	Labo	rer		me (First, Middle,		ries _{e)}	
	၀	Gordon 19a. Informant's Name/Relationship (7)	Quinn Type, Print)		Address (Street	Teres	a ural Route Number		Epps State, Zip	Code)
	-	Felicia Woodland 20a. Method of Disposition 1 🖁 Burial 2 Cremation 3 🗆 1	Removal from State	 Place of Disposition cometery, cremate 	on (Name of ory or other place	ce)		20c. Location -		
once.		21. Signature of Funeral Service Licens			PK. ame and Addres rch F.H	ss of Facility		Randal imore, N North	۱d.	wn, Md. 21202
an cal		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	eath. Do not enter to	he mode of dyin	g, such as cardia			Ave.	Approximate Interval Between Onset and Death IS MINUT
ier	icai Examine	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons c. Due to (or as a cons d.	sequance of).						
		in the past 12 months?	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3 Ec	topic pregnancy ther (specify)			23d. Date Mon	e ol delive	ry Day Year
		9 Unknown								e cause of death?
	ρ '	9 □ Unknown Part II. Other significant conditions co	ontributing to death but not	resulting in the unde	rlying cause give	en in Part I.	11			ably 4 Unknow
	eted by		ontributing to death but not	resulting in the unde	rlying cause give	en in Part I.	1 Ye	n 24b. W	3 Proba	osy findings availal
	To Be Completed by	Part II. Other significant conditions co	Hospital: 1 ⊠ Înpatient 2	□ ER/Outpatient	3□ DOA Oth	26. Place of De	1 Ye	n 24b. W P d d n n n n n n n n n n n n n n n n n	3 Proba	psy findings availal nplation of cause of 2 No
	To Be Completed by	Part II. Other significant conditions co	Hospital: 1 X inpatient 2 28a. Date of Injury (Month, Day Year,	EP/Outpatient 28b. Time of Injury	3 DOA Cth	26. Place of De	24a. Was a autops perform 1 Yes 2 at (Check only on dome 5 Reside 28d. Describe ho	n 24b. Wy p 24b. W p	3 Proba	osy findings availa npletion of cause (2 No
	Certification; To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier Check only 2 Medical Exam	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year, 28e. Place of Injury - A building, etc. (Spe	EER/Outpatient 28b. Time of Injury It home, larm, street, scify)	3 DOA Cthu 28c. Injun Worl 1 Sactory, office	26. Place of Dei er: 4 □ Nursing h y at k? Yes 2 □ No	24a. Whas a autops perform 1 Yes 2 ath (Check only on flome 5 Reside 28d. Describe how 28d. Location (St. City or Town	n 24b. W p p p p p p p p p p p p p p p p p p	3 Proba Vere autopnor to coneath? Yes or (Specify) ad	psy findings availal apletion of cause of 2 No
	ledical Certification; To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year, 28e. Place of Injury - A building, etc. (Spe ysicien: To the best of my inner: On the basis of exam and manner stated.	EER/Outpatient 28b. Time of Injury It home, larm, street, scify)	3 DOA Cth 28c. Injun Worl 1 Sactory, office	26. Place of De. er: 4 □ Nursing H y at k? Yes 2 □ No ne, date and place pinion, death occu	24a. Whas a autops perform 1 Yes 2 at (Check only on forme 5 Reside 28d. Describe how 28d. Describe how 28d. Location (St. City or Town a, and due to the caurred at the time, die 2	n 24b. W p p p p p p p p p p p p p p p p p p	3 Proba Vere autoprior to con eath? Yes or (Specify) ed or or Rural ar or Rural (Month, E	Route Number, ated. the cause(s)

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Stete Registrar	State of Marylan	d / Depa	artment of H	lealth and I Death		iene 20 (04 10123
	Physici /Medic		Decedent's Name (First, Middle, L JARROD	ast)		CARLTON		2. Date of Death	30° 20°	3. Time of Death 7 A M
-	Examir		4e. Facility Name (If not institution, g. 500 WESTSIDE BI	_VD.		CATONS			4c. County of BALTI	MORE
*	Funeral Director		5. Social Security Number 6. 212-06-5336 Usuet Residence of Decedent	Sex 7. Age (In yrs. I	Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JAN 26,	Year)	Birthplece (State or Foreign Country) MARYLAND
	Maryland	tor	MD 10b. County BAL	TIMORE 10c. City	y, Town or Lo	SVILLE				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with the 23a or 28	al Director	10e. Street and Number 500 WESTSIDE BL	.VD.		10f. Zip Code 212	228	10	g. Citizen of Wha	t Country?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "naturel', or items 23e or 28e-f show importent: If item 27 is marked other than "naturel', or items 23e or 28e-f show proprinty or other traumatic event, the Medical Exaction that must be notified at ances.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Si an, Mexican, Puerti Specify:	pecify Yes or No- p Rican, etc.)	14. Race - A Black, N Specify:	American Indian, White etc WHITE
21215-0036	ed within 72 hagiene. er than "natu	Completed	15. Decedent's 1 (Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired NONE	during most of wor d)	king	6b. Kind of Busin	ess/Industry
Maryland	should be filed nd Mental Hygid s marked other umatic event, II	To Be (17. Father's Name (First, Middle, Las	CARLTO			LAUREN		SCHNAPI	
	and 2 sh ealth and n 27 ls m		19a. Informant's Name/Relationship DR. JAMES CARL	ON (FATHER)	1180	ng Address (Street and 1 BERANS		ra <i>l R</i> oute Number, HERVILLE		
altimore,	permit. Pages 1 a Department of Hes Importent: If item eny injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State	emetery, crer	sition (Name of natory or other plac RE HEBREW			Oc. Location - City	
Balti	permit. Departrimporte eny inju		21. Signature of Funeral Service Lice		22	Name and Address	ss of Facility SO	L LEVINS		S., INC.
	Physician		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the death one cause on each line. a	n. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Severe (Due to (or as a consequence)	Quad		Cereb			20 years
P.O. Box 6	that the death certificated by the attending placed by the attending placed for use as to	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	98	by	Part II. Other significant conditions	contributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.		~	e to the cause of death? Probably 4 □Unknown
al Records,		Completed	U					24a. Was an autopsy perform	prior deatl	e autopsy findings available to completion of cause of n?
Division of Vital	ng Phy fter this meral d	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	er: 4 Nursing Ho	th (Check only one one 5 🗖 Residen 28d. Describe how	ce 6 Other (S	Specify)
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not determined		me, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number o State)	r Rural Route Number,
	ne Hospital n 24 hours a ne Funeral bletely filled	Medical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my know miner: On the basis of examinati and manner stated.	wledge, death ion and/or inv	occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manne e and place, and	r as stated. due to the cause(s)
1	To the within 2 To the complet	×	29b. Signature and title of certifier	0		29c. License			d. Date signed (M	
	3		30. Name and address of person who	completed cause of death (Item	23a) (Type, I	Print)	0114	N	larch ?	31,2004
	Sta	te	ERIC, LEVEY A 31. Date-filed (Month, Day, Year) APR 0 2 2004	32. Registrar's Signat		BROADWA	Y BALTI	MORE, MD	21205	
	Registr	ar	MFK U & 2004	Dependent 10	de	racks/				

			1 - For State Registrar	State of Marylan	nd / Depa		Health and	Mental Hyg	giene leg. No. 200	
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	al	Alice M	Dunn	e	4b Cib. Town	, or Location of Dea	04	4c. County of Dea	1
	Examin	er	4a. Facility Name (If not institution, give s 2802 BUXMONT LANE	treet and number)		BOWI				GEORGES
	Funeral	1	Social Security Number 6. Sex		last birthday)	If Under 1 Yea	r If Under 24 Hrs	8. Date of Birti	PKINGE 9. Bit	thplace (State or Foreign
	Director		141-16-7771	M 2 □X = 78	Yrs.	Months Day	s Hours Min	SEPT.	9. Bii 9, 1925	PA
	pue *		Usual Residence of Decedent 10a. State 10b. County	10c. Gi	ty, Town or Lo	ocation		*		10d. Inside City Limits
	Aaryla raho ed al	or	MD PRINCE (BOWIE					1 X Yes 2 □ No
	the t	Director	10e. Street and Number	LORGES	DOWLE	10f. Zip Code			10g. Citizen of What C	ountry?
	death with the Maryland ms 23e or 28e-f ahow I must be notified at	ai Di	2802 BUXMONT LANE			2	0715		USA	
	ems ?	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of	f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
20	hours after lurel', or ite al Examine	by Fu	1 Never Married 2 Marned	1 ∐ Yes 2 🛣 No If Yes, Give		1□Yes 2\N				HITE
1215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than enaturel; or Items 23s or 28s-1 ahow avant, the Medical Evanance must be notified at	ed b	3 XWidowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Occ	unation	111	16b. Kind of Business	
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yland	be filed tal Hygi of other	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame)	
<u>X</u>		To	MICHAEL J. MARSHA					HA GRIMM		
Mar	12 sho h and 7 is m treum		19a. Informant's Name/Relationship (Ty) JAMES CROWNE / SON			ng Address <i>(Stre</i> BUXMONT			r, City or Town, State,	Zip Code)
	s 1 and 2 should f Health and Mer item 27 is marke other treumatic	3	20a, Method of Disposition	20b. F	Place of Dispo	osition (Name of		WIE, MD	20715 20c. Location - City or	Town, State
<u>ē</u>			1 Burial 2 □ Cremation 3 □R 4 □ Donation 5 □ Other (Specify)	emoval from State		matory`or other p ANS CEME		6/2004	CROWNSVIL	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License			2. Name and Add	rees of Capility			
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cords, r	w requires that the been signed by the should be detache	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause o	given in Part I.	23e. Did to	bacco use contribute t es 2 No 3 □ P	o the cause of death?
ů Ľ	The law ate has b page 2 si	Completed						24a. Whas a autops perfor 1 □ Yes	meg? death?	utopsy findings available completion of cause of
Vital	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:				ath (Check only or		
ō	ng Phys Viter this Ineral dii	lion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. In	ther: 4 Nursing I		ence 6 Other (Spe ow injury occurred	cify)
UIVISION	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, sti (y)			28f. Location (S City or Town	treet and Number or R n, State)	ural Route Number,
	he Hospit n 24 hours ne Funere	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicat Examin	sician: To the best of my knower: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time, d	ause(s) and manner a ate and place, and due	s stated. a to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	_		_	nse number	2	9d. Date signed (Mont	h, Day, Year)
)	. 6		tang 1	10		DI	4689		4/1/8	14
	b.		30. Name and address of person who co						,	
86.			JAMES Y. WANG, M.D. 31. Date filed (Month, Day, Year)	 14999 HEAL Registrar's Signa 	TH CENT	TER DRIV	E_SUITE#2	01 BOWIE	MD 20716)
	Sta Registr		APR 0 2 2004	A See Signal	Special	de la				

			1 - State Registrar	State of Maryl	and / Dep Ce	partme p <i>rtifica</i>	ent of He ate of D	ealth and N Death		giene 20	04 10125
	Physici /Medic		Decedent's Name (First, Middle, Last)	Virginia	L. D	avis			2. Date of Dea Month March	_	3. Time of Death 6:50A M
1	Examir		4e. Fecility Name (If not institution, give s Southern Maryland			1	y, Town, or Clinto	Location of Death		4c. County of C	George's
	Funeral Director		231 12 0203	7. Age (In 77)	yrs. last birthda Yrs.	y) If Unc Month	der 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay 3/14/2	Yeer) 9.	Birthplace (State or Foreign Country) est Virginia
	e Maryland a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge		. City, Town or I		ton				10d. Inside City Limits 1 ☐ Yes ঽঢ়ৢ৻No
	h with th	al Dire	10e. Street and Number 7708 Locust Lane			10f.	Zip Code 207	744		10g. Citizen of Wha	t Country? JSA
920	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be rediffied at	by Funeral Director		12. Was Decedent Ever in Armed Forces? 1 Yes XXNo If Yes, Give Year or Dates:	in U.S. 13			panic Origin? (Sp., Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, V	American Indian, White, etc. White
Maryland 21215-0036	d within 72 ho piene. r than "natur ine Medical.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation completed) College (1-4or 5+)	(Giv life.	re kind of t DO NOT	sual Occupativork done du use retired)	uring most of work	ing	16b. Kind of Busine	
yland ?	ould be filed Mental Hygid arked other atic event, II	To Be C	17. Father's Name (First, Middle, Last) Romey Statler					18. Mother's Nam Lula M.	Noggle	Maiden Sumame)	
	ges 1 and 2 should it of Health and Mer if Item 27 is marke or other traumatic		James Stuart Davis	Sr./Husban	1d 770	08 Lo	cust I	ane Ft.	Washing	r, City or Town, Stat ton, MPI 2	
Baltimore,	permit. Peges 1 a Department of Hes Important: If Item eny injury or othe		20a. Method of Disposition 1 ↑	emoval from State	b. Place of Disp cernetery, cri Id. Vete	erans	cother place. Cem.	04/01	Date /2004	20c. Location - City Cheltenha	m, Marvland
Balt	permit. Pe Departmer Important eny injury once.		21. Signature Funeral Service License 23a. Part. Enter the disease, or compli	100		LIDU I)yon H	of Facility orge P. K	alas Fu	neral Hom	e P.A. land 20745
	Physician /Medical		shock, or heart failure. List only or immediate Cause (Finat disease or condition resulting in death)	Due to (or as a con	ATIC					est,	Approximate Interval Between Onset and Death ADMITTED
68760,	Examine be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	CONCES Due to (or as a con Due to (or as a con	STIVE sequence of):		ART	PAIL	URE		3/25/04 expired 3/27/04 AT 6.50 AM
P.O. Box 68	death certifi e attending id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	□Ectopic	pregnancy specify)			23d. Date of Month	delivery Day Year
rds, P	quires that in signed b uld be deta	ed by PI	Part II. Other significant conditions con				cause given				e to the cause of death? Probably 4 □Unknown
Division of Vital Records,	ding Physician: The law requires that the I.h. After this certificate has been signed by th funeral director, page 2 should be detached.	Completed	CHRONIC OBS	TRUCTIVE	LUK	19 1	DISEA	KE	24a. Was a autops perform	med? prior death	autopsy findings available to completion of cause of 1?
f Vita	Physician: r this certifica ral director, p	To Be	25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	ospital:	2 CER/Outpatie	ent 3 🗆 l	Other	26. Place of Death		e ence 6 □Other (S	Specify)
ion o	ittending P death. ctor: After t y the funera		27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time Injury		28c. Injury a Work? 1 🗆 Ye	at es 2 □ No	28d. Describe ho	ow injury occurred	
Divis	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	ecify)				City or Town	1, State)	Rural Route Number,
	n 24 hou n 24 hou ne Fune oletely fii	Medicai	29a. Certifier (Check only one) Certifying Physical Examination Medical Examination	ician: To the best of my er: On the basis of exam and manner stated.	knowledge, dea nination and/or i	nvestigation	d at the time on, in my opin	, date and place, nion, death occurr	and due to the c ed at the time, d	ause(s) and manner ate and place, and o	r as stated. due to the cause(s)
)	To the Comp	¥	29b. Signature and title of certifier	and H.	> .		9c. License			9d. Date signed (Me 5 29 0	
	H		30. Name and address of person who con Satish N. Jumani	mpleted cause of death (1. D :	#200	Uala-	M	1 20000
* ·	Sta Registr	_	31. Date filed (Month, Day, Year) APR 6 2 2004	32. Registrar's Si		oore		v e #2U8	waluori	, Marylar	nd 20603

			For State Registrar	State of Maryland		artment of H		•	giene Reg. No. 200	4 10126
	Physici	an	Decedent's Name (First, Middle, Last)	0.0.				2. Date of De Month	ath Day Yea	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s Mer of Media 5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	4b. City, Town, or BAC If Under 1 Year Months Days	Location of Death I M WR If Under 24 Hrs. Hours Min.	8. Date of Birt	4c. County of D Bi4LT th y, Year) 9.1	
	Director		243–58–3539 Usual Residence of Decedent 10a. State 10b. County	65	Yrs. Town or Lo			2-19-	39	N.C.
	death with the Maryland ms 23s or 28s-f show Fraust be notified at	Director	Md. NA 10e. Street and Number		Baltin	10f. Zip Code			10g. Citizen of What	1 X Yes 2 □ No Country?
36	n 72 hours after death with the Marylan "natural", or Items 23a or 28a-1 ehow wdical Examinal mast be notified at	by Funeral	1121 S. Race Stre	2et 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:		212 Was Decedent of Hi f Yes, specify Cuba □ Yes 2 No		pecify Yes or No Rican, etc.)		merican Indian,
21215-0036	ified within 72 hou I Hygiene. other than "natural	Completed h	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 9th grade	cation	(Give	dent's Usual Occupa kind of work done o DO NOT use retired, Never Wo	luring most of work)	king	16b. Kind of Busine	
Maryland 2	o d is d	To Be C	17. Father's Name (First, Middle, Last) George	Yancey	7			e (First, Middle. ianna	Maiden Sumame)	Daymon
	1 and Health em 27 ther tr		19a. Informant's Name/Relationship (Ty) Erneser Daymon 20a. Method of Disposition	Daughter	191	g Address (Street a 2 E. 20th sition (Name of	Street,		or, City or Town, State Ore, Md. 20c. Location - City	21218
Baltimore ,	nit. Page: artment o ortant: If injury or I.		1 Description 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State Ar	netery, cren butus	Mem. Par Name and Addres	k 4-5-	04	Arbutus,	Md.
B	permi Depa impo any ir		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death.		March F.F		1101 E	. North Av	21202 7e. Approximate Interval Between
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate		AL	Fibril	hock	3		Onset and Death 1-2-hours
8760	death certificate be executed e attending physician and rd for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):	y A	ney	Puse	enge_	unbucing
.O. Box 6	the death certif / the attending ched for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 18 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Pay Year
ords, P.	w requires that been signed by should be deta	þ	Part II. Other significant conditions con	tributing to death but not result	ing in the ur	iderlying cause give	n in Part I.			to the cause of death? Probably 4 Unknown
Division of Vital Records,	The la ate has page 2	Completed							sy prior t ned? death 2 No 1 Y	autopsy findings available o completion of cause of es 2 No
f Vit	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 No	ospital:		t 3☐ DOA Othe	26. Place of Deat 1: 4 ☐ Nursing Ho		ne) lence 6 □Other (Si	pecify)
sion o	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death 1	(Month, Day Year)	b. Time of Injury		at ? ′es 2 □ No		ow injury occurred	
Div	oltel or At urs after d srai Direct	Certifi	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)				City or Tow		
	To the Hospitel of within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) Certifying Phys Medical Examin 29b. Signature and title of certifier	sician: To the best of my knowler: On the basis of examinatio and manner stated.	edge, death n and/or inv	estigation, in my op	inion, death occur	red at the time, o	cause(s) and manner date and place, and d 29d. Date signed (Mo	ue to the cause(s)
	¥ ¥ ₽ 8		1 Set Mr.	Komp		D	40166		March.	30 2004
	7		30. Name and address of person who co	mpleted cause of death (Item 2	3a) (Type, I	Fina and	my Ma	alcus 3	BUISTA	on Place
	Sta Registr		31. Date filed (Minth, Day, Year) APR	32. Registrar's Signatur		Lord				2,201

02207	1	For State Registrar AMEND TIEM #2		f Maryland 331 5/28/ 0						-	giene Reg. No.	04.	- <i>i</i> c	127
Physician	1	1. Decedent's Name (First, Middle, L FLORENC	ast)							2. Date of De. Month March	Day	Yee 200	er l	3. Time of Death
/Medica Examine		a. Facility Name (If not institution, go SUBURBAN HOSPITA		mber)			Town, or CHESI	Location o	-		4c.	County of D	eath	
Funeral Director		N/A	Sex 1 □ M 2 X F	7. Age (In yrs. las 48	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Pa 11/2	1h 18/55		Birthplac Country RANC	
death with the Maryland me 23e or 28a-f show result to nutified at parest Director		Usuel Residence of Decedent 10a. State 10b. County MD MONTO	OMERY	10c. City, 1 NORT BETT	Town or Lo	cation							100	I. Inside City Limits 1 ☐ Yes 2 🕅 No
vith the Mar or 28a-f st be notified	2	10e. Street and Number				10f. Zip					10g. Citiz	en of What	Country	y?
ō ₽ ₽ .	Dy Fulleral	5809 NICHOLSON L 11. Marital Status 1 Never Married 20X Married 3 Widowed 4 Divorced		edent Ever in U.S. prces? 20 No		Was Deced	ify Cuba	spanic Ori n, Mexicar Specify:	i, Puerto	ocify Yes or No Rican, etc.)		NCE 4. Race - A Black, W Specify: V	hite, etc	C.
15-0(Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12TH GRADE	Education	1-4or 5+)	(Give life.	dent's Usua kind of wor DO NOT us	k doné d e retired,	ution u <i>ring</i> mos	t of worki	ng		nd of Busine		stry
be filed with tal Hygiene. d other there event, Iron		17. Father's Name (First, Middle, Las		T	HOM	EMAKEF	X	18. Mothe	er's Name	(First, Middle,		N HOMI Sumame)		
iryland 212: should be filed within and Mental Hygiene. marked other then matic event, the M	2	HENRI CARADELLI		- 1						LLABRES				
Maryla and 2 should lith and Mer lith and Mer lith and merke traumatic	and the same of	19a. Informant's Name/Relationship JEAN DELIMARD	(Type, Print)	1		0.972				l Route Numbe	5-10-29		000	
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 27 1 any injury or other tra	0	20a. Method of Disposition 1 🖫 Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spec		State cem	e of Dispo etery, crei	sition (Nam natory or ot E CEME	ne of ther place ETER	e) Z	4-3-		20c. Loc	ation - City	or Town	n, State E
Balti permit. Departin Imports any inju		21. Signature of Funeral Service Lice WILLE EDMON		er dvr	22	2. Name and	d Addres	s of Facilit	MARO ENUE	CH FUNE , BALTI	RAL I MORE	HOME V	212	T.)
Pnysician /Medical	The second second	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	y one cause on e CAF a	aused the death. each line. RDIAC ARR (or as a consequer	HYTHI		of dying	, such as	cardiac o	r respiratory ar	rrest,		lr.	pproximate hterval Between onset and Death
Examiner	<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D. —	ECAINIDE (or as a conseque		KICATI	ON							
8760, cate be executed only sician and the burial-transit	LYG	Cause (Disease of Injury that initiated events resulting in death) Last	c. Due to d	(or as a consequer	nce of):									
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	2	Part II. Dther significant conditions	contributing to de	eath but not resultin	ng in the u	nderlying ca	use give	n in Part I.	-	11	obacco us res 2 🖸	_		cause of death?
The law ate has by page 2 s	combien											24b. Were prior to death 1 🔀 Y	autopsy to comp ? es 2(y findings available letion of cause of
	מ	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital:	Inpatient 2□ER	2/Outpation	4 2 DO	Othe			(Check only o		D011/0	41	
on of V ding Physi h. After this of funeral dire		27. Manner of Death			Outpatier b. Time of Injury		Bc. Injury Work	at		ne 5 🗆 Resid 28d. Describe h			рөсіту)	
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Division or Attendure after death real Director:	Certification	4 Homicide determine	HOME	of Injury - At home ing, etc. (Specify)					5		vn, State) CHOLS	ON LA	NE ESD	NORTH A. MD
To the Hospitel of within 24 hours at To the Funerel D completely filled it	Medical	29a. Certifier (Check only onal 2 Medical Example 1 Certifying F 2 Medical Example 1 Certifying F	aminer: On the b	 best of my knowle asis of examination ner stated. 	edge, deat n and/or in	n occurred a vestigation,	in my op	e, date an inion, de <i>a</i>	d place, a th occurre	and due to the o	cause(s) a date and p	and manner place, and c	as state lue to th	ed. e cause(s)
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		J. LARON LOCKE,	o completed caus M.D.	111 PENN		,	ALTI	MORE	, MAF	RYLAND 2	21201	-		
State Registra	7	31. Date filed (Month, Day, Year) MAY 2, 8, 2004		legistrar's Signatur	9	als								

			1 - State Registrar	State of Mary	land / Depa <i>Ce</i>	artme <i>rtifica</i>	ent of H ate of L	ealth an D <i>eath</i>	d Mental Hy	giene 2 (04	101	28
	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of De Month	Day	Year	3. Time of D	
>	/Medio	al	Oliver L. Das 4a. Facility Name (If not institution, give			4b. Ci	v. Town, or	Location of D	April	4c. Count	004 v of Death	5:50 A	M
	Lxamii	ei	Quail Run Assiste				Perry				ltimo		
	Funeral Director		213 10 3021	7. Age (In	yrs. last birthday) 4 Yrs.	If Und Month	ier 1 Year s Days	If Under 24 Hours	Hrs. 8. Date of Bir Min. (Month, Da NOV • 1	th Year) 1919	9. Birth Cou New	place (State or I	Foreign
	/land		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation						10d. Inside City	Limits
	e Man	ctor	Maryland Baltimo	re			Kings	ville				1 ☐ Yes 2	2 No.
	with th	Director	10e. Street and Number 12204 Glenbauer i	Poad		10f. 2	Zip Code	01067		10g. Citizen of		intry?	
	ms 23	Funeral		12, Was Decedent Ever	in U.S. 13.	Was Dec	edent of His	21087 spanic Origin	? (Specify Yes or No uerto Rican, etc.)	- 14. Ra		can Indian,	
920	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or flems 23a or 28a-f show imetic event, Its Medical Examinating to incitible at	by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:				Specify:	uerto Rican, etc.)	Specii	ck, White ' ^{y:} Wh	ite	
5-0036	72 ho natura	eted	15. Decedent's Edu (Specify only highest grade		(Give	kind of v	sual Occupa	uring most of	working	16b. Kind of B	usiness/Ir	ndustry	
Maryland 2121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			use retired) Engi			Martin	Mari	otta	
10 2	iled within Hygiene. Other ther	Be Co	17. Father's Name (First, Middle, Last)	2	1,1000				Name (First, Middle			eccu	
ylar		To B	Oliver L. David	dson, Sr.					rude A.				
Mar			19a. Informant's Name/Relationship (Ty Mrs. Rose B. David						Rural Route Numb				
	tem 2		20a. Method of Disposition		Ob. Place of Dispo	sition //	lame of		d, Kingsun Date	20c. Location		087 own, State	
E O	Pages nent of int: If it ury or o		1 X Burial 2 □ Cremation 3 □ R 14 □ Donation 5 □ Other (Specify)	emoval from State	cometery, crei Moreland		,	· 1	3/2004	Baltimo	re.	Marulan	d
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 I sny injury or other tre Once.		21. Signature of Funeral Service License	The state of the s	22	2. Name	and Address	s of Facility	Schimunek Baltimo	Funeral	Hom	es	
o o	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.			0			rrest,		Approximate Interval Betwe Onset and De	en eath
	/Medical Examiner		resulting in death)	Due to (or as a co	TES		-	17 140)(X/ F)				
1 8	LAGIIIII	2	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence of):	14	622	1111	5				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	MAL XU	OTRI	FI	OX						
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Box 6	r death certificate be executed te attending physician and ed for use as the burial-transit	Physician/Me	in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of pr 1 Live birth 2 4 Pregnant at time	Fetal death 3	Ectopic Other (pregnancy specify)				te of deliventh	ery Day Yea	ar
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ords,	law requires that the as been signed by th 2 should be detache	by	Partil, Other significant conditions con	insputing to death but no	r resulting in the di	nderlying	cause give	n in Part I.		obacco use cont res 2 No	3 Prot		
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ta	ician: Th certificate rector, pag	0	25. Was case referred to medical				-	26 Place of I	1 ☐ Yes Death Check onl o	2 No	☐ Yes	2 X No	
	Physici, this cer al direct	To B	examiner? 1 Tes 2 No	ospital: 1 🗆 Inpatient	2 ER/Outpatien	t 3 🗆 0	Otho		g Home 5 Resid		er (Specit	Assiste	ed
n of	ding Ph h. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury		28c. Injury Work	?	28d. Describe h	now injury occur	ed	Lavang	
Division	or Attendi after death. Director: A in by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury	At home, farm, str	M eet, facto		es 2□No	28f. Location /5	Street and Numb	er or Rura	I Route Numbe	91
2	s after al Direct	Certification;	4 Homicide	building, etc. (S)	pecify)		, J.		City or Tox	vn, State)	0, 0, 1,2,		*,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edicai	29a. Certifier 1 Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Control of the Certifier Cer	sician: To the best of my ser: On the basis of exa- and manner stated.	knowledge, death mination and/or inv	occurre estigation	d at the time on, in my opi	e, date and pla inion, death o	ace, and due to the courred at the time,	cause(s) and ma date and place,	nner as s and due to	tated. the cause(s)	
	To the To the ccmpl	Me	29b. Signature and title of certifier			2	9c. License	number		29d. Date signe			
l	1		Chicuder	16 Xell	MB.		02	718	8	4-2	-0	4	
	/		30 e and addres of person who co	mpleted cause of death	(Item 23a) (Type,	Print)	A	Plan	0 71	4 - 2 4 Sele	1	200	חבי
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14	Registr	ar	APR 0 2 2004	Cleper /	0 1000	uns							

State of Maryland / Department of Health and Mental Hygiene 2004 10129 1- State Registrar AMEND ITEM # 31per dvr g 830 4/02/02/emificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Francis March 31 2004 Charles 12:20A /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Locust Lodge Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 16 1919 9. Birthplace (Stete or Foreign **Funeral** Months Mary land 18 M 2□ F 217-09-4791 84 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-1 ehow ury or other traumatic event, Ital Medical Examinating to notified at 1 ☐ Yes 2 No Funeral Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 156 Park Road 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: Specify: Be Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Marine Engineer Tug Boat 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Efford Buelah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Babbington 8481 Bussenius Road Pasadena, MD 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department o Important: If eny injury or once. * 4 Donation 5 Other (Specify) Metro Crematory Inc. 4/1/04 Baltimore Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 3111 Mountain Road tallings Funeral Home P.A. 23a. Part Enter the dis or complications that caus shock, or heart failure. List only one cause of each eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ructive lung Disause Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ned by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ₽ffobably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 18513/16 4 VIN 1 Yes 2 No Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and little of certal er 29c. License number 04 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher debora sadera MD 3700 Mountain 11 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** OERTSCHBECK /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 216HTWOOD Utheruille Genesis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 20 F Months 462-40-6422 Usuel Residence of Decedent Yrs. Director Ken permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mentel Hygiene. Department of Health and Mentel Hygiene important: If Item 27 is marked other than "naturel", or hems 23s or 28s-f show any Injury or other traumetic event, the Medical Examinar must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Director BALTIMORE BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2808)SH by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Meritel Stetus Armed Forces?

1 Yes 2 No
If Yes, Give 2 Married 1 ☐ Never Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homema 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) BALTIMORE MD 20a. Method of Disposition

1 Burial 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) FOREST HILL, MO EVANS FUNERAL CHAPEL-BELAR 22. Name and Address of Facility BALTIMORE, MD 21234 21. Signature of Funeral Service Licensee EVANS FUNERAL CHAPFL 8800 HARFOLD RD. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) MONTHS Examiner Physician/Medical Examiner inding physician end use es the bunal-transit or Attending Physician: The law requires that the death certificete be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 → Unithown Be Completed by 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was en autopsy performed? 1 Yes 2 4 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funerel Director: After 1-ENaturel 5 Pending investigetion 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide Hospitai 29a. Certifier Varifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier MARCH 29 5 2004 D0053150 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) BACK RIVER NECK RD UPTA 201-ShAWNMAC 32. Registrer's Signature 31. Date filed (Month, Day, Year) State APR 02 2004

Registrar

			1_ For State	State of Marylar	nd / Department of I			200h	10131
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of		Reg. No.	2004	3. Time of Death
*	Physici	an	Torach Co	lungal E	, , , , , , , , ,	Mo			1:00A.M
	/Medi		4a. Facility Name (If not institution, give	street and number)	erence	or Location of Death		2004 County of Death	7,007(
	Examir	ıer	Stella Maci	5 4030ic	o Timo	_		ALTIMO	A.E.
2.3	Funeral		5. Social Security Number 6. Sep	7. Age (In yrs.	last birthday) If Under 1 Year	If Under 24 Hrs. 8, Dat	e of Birth		lace (State or Foreign
	Director		214-18-2770	M 2□F 7. Agel (In yrs.	A Yrs. Months Days		nth, Day, Year)	MAR	VIANA
3,63			Usual Residence of Decedent			,,,,		1.(.1.	721100
	show	_	10a. State 10b. County		ty, Town or Location			1	0d. Inside City Limits
	88-1 s	cto	MD BALTIN	NORE	BALTIMOR	E			1 ☐ Yes 2 No
	or 2	Dire	10e. Street and Number		10f. Zip Code	-0.1	10g. Citi	zen of What Coun	itry?
	s 23e	rai	3514 Fleet St		217	229		UDH	
	er de Itam	une	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Specify Ye an, Mexican, Puerto Rican,	s or No- etc.)	 Race - Americ Black, White, 	
36	Ir, or	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	t □ Yes 2 🗖 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify: / 1	ite
5-0036	2 hou	ed	15. Decedent's Edu		16a. Decedent's Usual Occur	pation	16b. Kii	nd of Business/Ind	dustry
215	within 72 hours after death with the Maryland ane. than "natural", or Itams 23e or 28e-1 show he Madical Examiner mast be notified at	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of working d)			
21	d with	Completed	Signification (5 12)	00110g6 (1 401 07)	Draft smo	\n	Gle	enn L.	Martin
	be filed tal Hygie d other	Be C	17. Father's Name (First, Middle, Last)		•	18. Mother's Name (First,	Middle, Maiden	Sumame)	
/lai	should b ind Ments marked umatice	10	Michael Feri	ence		Rose K	UZM	a	
Maryland	C1 00 - 10		19a. Informant's Name/Relationship (Ty		19b. Mailing Address (Street	- 1 / 1			and the second
	1 and Health em 27 sther tr			daughter	2720 Alde	n Md., BALT	TIMORE	cation - City or To	1234
ore	Jes 1 I of H If ite		20a. Method of Disposition 1	emoval from State	Place of Disposition (Name of cometery, crematory or other pla	CO)			
ij	tment: ent: jury		`4 Donation 5 ☐ Other (Specify)	VH.	Stanislaus Cen	N. 3-31-0	14 BH	LTIMOR	E MD
Baltimore	perm t. Pag Department Importent: any injury c		21. Signature of Funeral Service Licens	1 1-1	22. Name and Addre	ess of Facility BACTIC	nurei m	D 2123	4.
	40569		Trubelly 4.	willy	EVANS FUL	UERALCHAPE	T'8800	HARFORK	
			23a. Pert1. Enter the disease, of complishock, or heart failure. List only or	e cause on each line.	n. Do not enter the mode of dyl	ng, such as cardiac or respir	atory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ENCEPHALOPA					
1.5	Examiner			Due to (or as a conseq	uence of):				
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):				
	uted 1 ansit	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
Ć,	be executed ician and burial-transit	Examiner	resulting in death) Last	Due to (or as a conseq	uence of):				
8760	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai		l					
9	tifica ng phy as th	led							
Вох	death certifica attending ph for use as th	Z	230. Mas decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		M.	2	3d. Date of deliver	*
	ne deal the att hed fo	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d		,		Month	Day Year
P.0	that the de ed by the detached	by Physician/Me	9 Unknown						
	res tha igned be det		Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying cause given	ven in Part I. 23		se contribute to the	
ord	w requir been si should	ted					1 Yes 2	JNo 3 Proba	ably 4 Xunknown
of Vital Records,	elaw hasb je2st	Completed				248	a. Was an autopsy	prior to com	sy findings available apletion of cause of
= H		ပ္ပ				1	performed? Yes 2 🛣 No	death? 1 ☐ Yes	2 🗆 No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	itali		26. Place of Death (Check		Cities -	
of	S &	မ	TE TES ZINO		ENOUIDATION 3 DOX	er: 4 ☐ Nursing Home 5[HOSPICE
Ę.	ding f	io io	27. Manner of Death 1 ▼Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Wor		scribe how injury	occurred	
isi	Attending r death. ector: After by the fune	icat	2 Accident Investigation 3 Suicide 6 Could not be	28a Place of Injury . At he	ome, farm, street, factory, office	Yes 2 □ No	ation /Street and	d Number or Rural	Clause Mumber
Division	after Direct In by	Certification:	4 Homicide determined	building, etc. (Specif	y)	City	or Town, State)	I Number of Hurai	Houte Number,
	spitel cours nerel filled		29a. Certifier 1X Certifying Phys	ician: To the best of my kno	wiedge, death occurred at the til	me, date and place, and due	to the cause(s)	and manner as sta	ted
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Examinations)	ner: On the basis of examina and manner stated.	tion and/or investigation, in my o	ppinion, death occurred at the	e time, date and	place, and due to	the cause(s)
	To th Yo th compl	Me	29b. Signature and title of certifier		29c. Licens	e number	29d. Date	signed (Month, D	Day, Year)
			1		Du	17771		3/29/0	4
	N		30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type, Print)			1-1/-	1
			DR. TARIQ MAHMOO		NEY VALLEY RD.	TIMONIUM, MI	21093		
	Sta		31. Date file W Porth, Day Year 004	82 Registraris Signa	don't				
	 Reaisti 	200			11				

MARCH 27, 2004 1:00 a.m.

JOSEPH FERENCE

			1 For State	State of Maryland		nt of Health and te of Death		200	10100
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	tanes Foos	Certifica	le of Death	2. Date of Death Month	Day 7 200	3. Time of Death 1 12:05 A M
	Examin Funeral Director		4a. Facility Name (If not institution, give s 5. Social Security Number 6. Sex 211 - 34 - 5095 1 Usual Residence of Decedent	IOR	Ri	y, Town, or Location of Dea	s. 8. Date of Birth	4c. County of Deal O C J Baar) 9. Bin G0 G1 G1 G1 G1 G1 G1 G1 G1 G1	th inplece (State or Foreign syntry)
	e Maryland la-f show	ctor	10a. State 10b. County MD Harlok	10c. City	y, Town or Location	ille			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	eath with th	Funeral Director	3740 Jarrel Status	toville Pike	2	ip Code 21084 adapt of Hispanic Origin? (Citizen of What Co	
9036	72 hours after death with the Maryland natural', or items 23s or 28s-f show deal Examiner must be natified at	by	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Origin? (: ecify Cuban, Mexican, Puel 252 No Specify:	no Rican, etc.)	Black, Whit	
21215-0036	- 200	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	cation e completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of w life. DO NOT	ork done during most of wo	prking 16	b. Kind of Business	Industry
Maryland	should be filed withir nd Mental Hygiene. marked other than imatic event, the Ma	To Be C	17. Father's Name (First, Middle, Last)	Schott	7.07.07	Em	me (First, Middle, Mai	Leus	,
	1 and 2:		19a. Informant's Name/Relationship (Ty, 20a. Method of Disposition	S, JR-SON (200. P)	3740 Salace of Disposition (Na		Pike Japa	ity or Town, State, 2	MD 21084
Baltimore,	artmer ortant injury		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	lemoval from State	emetery, crematory or AUUX 22. Name a	Pau Cowel and Address of Facility	2004 B	allimore refail Ci	MD
8	Ped		23a, Parl 1. Enter the disease, or complishock, or heart failure. List only or	calions that caused the death	n. Do not enter the mo	WOOLT DR. ode of dying, such as cardia	FOROT A	ell, MD	Approximate Interval Between
	Physician /Medical Examiner		Immediale Cause (Final disease or condition resulting in death)	Due to (or as a consequ		art failu	re		Onset and Death
,	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ				11	
68760,	ificate being physicial	cai		J					
.O. Box	ies that the death certifica igned by the attending ph be detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 € No 9 □ Unknown	3c. If yes, outcome of pregnal 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 Ectopic			23d. Date of del Month	ivery Day Year
<u>α</u>	The law requires that the tee been signed by the bage 2 should be detache	ted by Ph	Part II. Other significant conditions con		ulting in the underlying	cause given in Part I.	23e. Did tobac	3	the cause of death?
al Reco							24a. Was an autopsy performed 1 Yes 2	prior to death?	stopsy findings available completion of cause of
Division of Vital Records,	S 0 0	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending Nacident investigation	1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)		0.0	Home 5 Residence 28d. Describe how		cify)
Divis	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, facto	ry, office	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ıral Route Number,
	he Hospi in 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one) 1 Certifying Physical Exemination (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occurred tion and/or investigatio	d at the time, date and plac in, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
)	To T	Z	29b. Signature and title of certifier	20 MI		D 005572	29d.	Date signed (Montl	h, Day, Year)
			30. Name and address of person who co		23a) (Type, Print)	+ Haused	e Groce	MA	1078
J	Sta Registr		31. Date filed (MAP) Ray (1992) 200	32. Registrar's Signat		Control 1			

State of Maryland / Department of Health and Mental Hygiene State Registrar AME D ITEM #10b-f PER FH G830 4/02/Over Inficate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 12:50 A M 31 2004 Anna Mara Fletcher /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Brooklyn Park Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7-1-1912 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 217-20-0691 91 Yrs Director MD Usual Residence of Decedent the Maryland 10b. County WORCESTER 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at MD Anne Arundel Glen Burnie OCEAN CITY 1 Yes 2 No Director 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 719 LOOP RD ŏ 7849 Crilley Road Apt. 21842 21060 Петь 23в USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 9 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 white Specify þ 3 Widowed 4 □ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient Important: If Item 27 Ie marked other that any injury or other traumatic event, Item, ODG. 12 Home maker Home Owner 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Sumame) Be Threasa O'Brian Robert В. Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Nancy Armiger/daughter 719 Loop Road, Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/2/04 Brooklyn Park, MD *4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Singleton Funeral Home 21. Signature Funeral Se Ce Licenses 1 Second Ave SW, Glen Burnie, MD 21061 M01364 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -0 7 day /Medical Due to (or as a consequence of): **Examiner** Due to gras a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 XNo 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 TYes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Teath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 5 Pending investigation 1 Natural Injury death. Diractor: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Diray 4 Homicide Certifving Physicien: To the best of my knowled e death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LANE, MD 606 NA 2AVINGES 21. HAMMONDS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 02 2004

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

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			1 = For State Registrar	stato of Marytan	Certificate of		Reg. N	2006	10131
	Dharia		Decedent's Name (First, Middle, Last)	1 1 1	F . 1 1		Date of Death		3. Time of Death
	Physic /Medi	cal		Viartha	1-isch bo	1ch /	pril o	2 Vear	4:05 AM
7	Exami	ner	4a. Facility Name (If not institution, give str	Λ 1	4b. City, Town, o	or Location of Death		c. County of Death	
	r		5. Social Security Number 6. Sex	7. Age (In yrs. I	(ast birthday) If Under 1 Year	If Under 24 Hrs. 8		n/a	(O:
	Funeral Director			4 2∏F 86	Months Dave	Hours Min.	Date of Birth (Month, Day, Year ug . 20 19	r) 9. Birthpi Coun	lace (State or Foreign try)
	pu ,		Usual Residence of Decedent			A	ug.20 19		yland
	shov	5	Md. Anne Arun		y, Town or Location Pasadena			10	Od. Inside City Limits
	the A	rect	10e. Street and Number	der co.	10f. Zip Code		100.0	itizen of What Coun	1 ☐ Yes 2 No
	y within 72 hours after death with the Maryland liene. r than "natural", or items 23a or 28a-1 show the Medical Experiment must be notified at	Completed by Funeral Director	627 B Street		21122		10g. C	U.S.A.	uyr
	Items 2	ner	11. Marital Status	. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Decedent of H	Hispanic Origin? (Specify an, Mexican, Puerto Rica	Yes or No-	14. Race - America	
36	, or it	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give	1 ☐ Yes 2 🗓 No	Specify:	iii, e(c.)	Black, White, e	nite
21215-0036	hour tural	ed b	3 XWidowed 4 ☐ Divorced 15. Decedent's Educa	Year or Dates:	16a. Decedent's Usual Occup		100		
215	nin 72 In "na Medic	plet	(Specify only highest grade of Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give kind of work done life. DO NOT use retired	during most of working	160. 1	Kind of Business/Ind	lustry
213	전 등 L 201	E	12	O	Lunch Aid		Ci	ty of Bal	timore
pu		Be	17. Father's Name (First, Middle, Last)	77		18. Mother's Name (Fi			
<u></u>		1º	Jospeh	Kaminski		Helen		Cehynski	
Maryland	s 1 and 2 should f Health and Mer Item 27 is marks other traumatic		19a. Informant's Name/Relationship (Type Joseph Fischbach	(Son)	19b. Mailing Address (Street 627 B. Street				Code)
	Health tem 27 other tr		20a. Method of Disposition		lace of Disposition (Name of emetery, crematory or other place			ocation - City or Tov	wn. State
Baltimore,	00-		1 X Burial 2 ☐ Cremation 3 ☐ Ren 1 Donation 5 ☐ Other (Specify)		emetery, crematory or other plac idon Park Cemet			ltimore,	
alti	arth orts inju		21. Signature of Funeral Service Licenses	20)		slov Facility 1 yniak			
8	Per Per Per Per Per Per Per Per Per Per		free S.	Machine	3204	Mountain Ko	oad, Pasa	dena, Md.	21122
ŧ			23a Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death cause on each line.	. Do not enter the mode of dyin	ng, such as cardiac or res	spiratory arrest,		Approximate Interval Between
	Physician		fimmediate Cause (Final disease or condition resulting in death)	U-	ementia				Onset and Death
	/Medical Examiner		resolding in dealiny	Due to (or as a consequ	rence of):				
1		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a curisequi	terice of).				
	outed ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
ğ	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequent	rence of):				
8760	y s	dlcal	d						
89 x	The law requires that the death certifica tte has been signed by the attending ph age 2 should be detached for use as th	Physician/Med	IF FEMALE:	If yes, outcome of pregnan	nev				
Вох	death atten	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal 4 Pregnant at time of de	death 3 Ectopic pregnancy			23d. Date of deliver Month	y Day Year
P.O.	t the c by the	hysl	9 Unknown	9□Unknown					
S, F	es tha gned be del	by P	Part II. Other significant conditions contri		iting in the underlying cause give	en in Part I.	23e. Did tobacco	use contribute to the	cause of death?
ord	requir sen si nould l	ted	Dysphagio	1 1	1		1 ☐ Yes 2	□No 3□Proba	bly 4 Unknown
lec	has be	Completed	Dia better	Melli	tus		24a. Was an autopsy	24b. Were autop:	sy findings available
al F			Kecurent-	Urinary	Tract Ir	rtection	performed? 1□ Yes 2☑ No	death?	ENo
Ž	Physicien: r this certifica ral director.) Be	25. Was case referred to medical examiner? 1 Yes 2 No Hos	pital:	ER/Outpationt 30 DOA Othe	26. Place of Death (Ch			
of	ding Phys	n: To		28a. Date of Injury	28b. Time of linjury Work	4 Virusing Home	5 Residence Describe how injur		
ion	Attending death. ctor: Afte y the fun	atloi	1	(Month, Day Year)		<br Yes 2 □ No		.,	
Division of Vital Records,	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Al hon building, etc. (Specify)	me, farm, street, factory, office	28f. I	ocation (Street and	nd Number or Rural i	Route Number,
٥	urs aft ral Di					10			
	To the Hospitel or Attending Physicien: To the Planting 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifying Physici 2 Medical Examiner	: On the basis of examination	rledge, death occurred at the tim on and/or investigation, in my op	ne, date and place, and opinion, death occurred at	the time, date and) and manner as stated place, and due to the	ted. he cause(s)
	o the	Med	29b. Signature and title of certifier	and manner stated.	29c. License			te signed (Month, Da	
)	- > - 0		1 My	nons	2	55391	/A 0	ri 101,	2004
	5		30, Name and address of person who come	leted cause of death (Item :	23a) (Type, Print)			1	
			Ming 4, 3320	Denson /	quenue. 1	saltimore	, Mary	yland	12215
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure #	79			
4	riegisti	48	APR 0	S ZUU4	a de Someto	3			

			1 - For State Registrar	State of Maryland	l / Depa		Health and		-	
	Physici /Medic	_	1. Decedent's Name (First, Middle, Las	georgius	JR.			2. Date of De Month		M
)	Examin Funeral Director	er	5. Social Security Number 6. Se	Maylans	st birthday) Yrs.	BALT:	or Location of Dea	s. 8. Date of Bin	4c. County of De Not App 1 th ay, Year) ry 5,1954 Ma	eth .icable inthplace (State or Foreign
	TO	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Aru	10c. City,	Town or Lo			TOPTUA	1 9 3 , 133 7 116	10d. Inside City Limits 1 □ Yes 2 ☒ No
	th with the 23a or 28a	al Director	10e. Street and Number 621 North Hammon	ds Ferry Road		10f. Zip Code 2109	0		10g. Citizen of What (
920	i within 72 hours after death with the Maryland liene. I than "naturel", or Itame 23a or 28a-f show The Medical Examiner must be motified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates:		Vas Decedent of f Yes, specify Cu 1 ☐ Yes 2 🔀 No	Hispanic Origin? (ban, Mexican, Pue o <i>Specify:</i>	Specify Yes or No rto Rican, etc.)	14. Race - An Black, Wr Specify:	
1215-0	n 72	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation te completed) College (1-4or 5+)	(Give lite. 1	dent's Usual Occu kind of work done DO NOT use retin	ipation a during most of wo ad)	orking	16b. Kind of Busines	,
Maryland 21215-0036	be filed tal Hyg d otherwent,	To Be Co	17. Father's Name (First, Middle, Last)	rgius, Sr.	116	SIGENC	18. Mother's Na Evelyr		, Maiden Sumame)	Construction
	s 1 and 2 should if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (7 Lillian Georgia	is-Wife	621 N	orth Ham	monds Fe			m, Maryland
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify 21. Signature Preparation in Licen:	Loud	lon Pa		ery 3-3	1-2004	20c. Location - City of Baltimore	, Maryland
Ba	Departic Departic Imports eny inji		23a. Part 1 Enter the disease, of comp shock, or heart failure. List only of	rsow						yland 21229 Approximate Interval Between
760,	Physician and Macing Examiner We private and physician are physician are physician and physician are physician are physician are physician are physician and physician are physician are physician are physician and physician are physician and physician are physician and physician are physician ar	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		ence of): OOS ence of):	(Synir Backe	SLOME	riton		Onset and Death
.O. Box 68	at the death certificate by by the attending physicached tached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnant 1 Live birth 2 Fetal of 4 Pregnant at time of deal 9 Unknown	beath 3⊑	Ectopic pregnand Other (specify)	Çy .		23d. Date of do	elivery Day Year
٥.	ires that signed b d be deta	leted by Ph	Part II. Other significant conditions co	ntributing to death but not result	ting in the ur	nderlying cause g	ven in Part I.		obacco use contribute Yes 2□No 3□F	to the cause of death?
Vital Records,		Сошр						24a. Was autop perfo 1 □ Yes		
o o	Attending Physician: sr death. ector: Atter this certific by the funeral director.	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Man er of Death 1 Vatural 5 Pending investigation		R/Outpatien 28b. Time of Injury	28c. Inju	her: 4 🗆 Nursing I	7	one) ` dence 6 □Other (Sp how injury occurred	ecify)
Division	Dir Dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (City or Tos	Street and Number or F vn. State)	iural Route Number,
n	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical	(Check only 2 Medical Exam	rsician: To the best of my know iner: On the basis of examination and manner stated.	ledge, death on and/or inv	estigation, in my	opinion, death occ	urred at the time,	date and place, and du	e to the cause(s)
)	To To Corr	Σ	29b. Signature and title of certifier 30. Name and address of person who certifiers		23a) (Type,	AUU	176435 K1529	7	29d. Date signed (Mon	th, Day, Year)
-	Sta Registr		31. Date filed (Month, Day, Year) APR 0 2 200	32. Hogistrar's Signatu	ire &	Spark				

State of Maryland / Department of Health and Mental Hygiene 2004 10136 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 5:28am[™] March 2004 John Garren, Jr. 28 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Havre de Grace
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Harford Harford Memorial Hospital 8. Date of Birth (Month, Day, Year) 06/13/1939 Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 ☐ F 64 Yrs. 144-30-6707 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or items 23a or 28e-f show vent, it a Medical Examiner must be notified at 1X Yes 2 ☐ No MD Harford Havre de Grace Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 350 Fountain Street 21078 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 20 years Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electronic Technician U.S. Government GED 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event once. 17. Father's Name (First, Middle, Last) Be John Garren Sarah Blauvelt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anne B. Garren- Wife 350 Fountain St., Havre de Grace, MD 21078 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Grdns. 04/02/04 Aberdeen, MD . Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. Maire 123 S. Washington, Havre de Grace, MD 21078 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ardiophl monary Physician /Medical Due to (or as a consequence of): Examiner Coronary Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exacts) The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Mnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 30 No 1 ☐ Yes 2 ☐ No 1 ☑ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 28c. Injury at Work? After the funeral 28a. Date of injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 6 within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058904 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Henrede Grace MD 21075 Inon Avenue MD 319 Lee South L Jeona 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 0 2 2004

DHMH 17 Rev 1/2001

John Garrer

ORIGINAL

			For	State of Marylan			Mental Hy	giene	
			- State RegistrarAMEND ITEM #10	c,-g PER FH G830	4/02/Poartifica	te of Death	2. Date of Dea	Reg. No. 200	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Las	Gleichen			Month	Day Year	745
	/Medic Examin		4a. Facility Name (If not institution, give			y, Town, or Location of Dea	th /	4c. County of Dea	·
			1100011100	enty Genera	& Hosp.	er 1 Year If Under 24 Hrs	Md.	1700	
	Funeral Director		5. Social Security Number 6. Sec. 1)	X 7. Age (In yrs.	Yrs. Month			Year) 9. Bir	thplace (State or Foreign ountry)
			Usuel Residence of Decedent	100 6	ty, Town or Location		102/02		10d. Inside City Limits
	Aarylan F show	ō	MD. 10b. County	ward	Fullon	ELLICOTT CITY			1 Tyes 2 No
	r 28a-	Director	10e. Street and Number 5320DORS			Zip Code		10g. Citizen of What C	
	23a o 23a o usi be		12401 1	ne Kiln K	-d.	20759210		Hower	10
	iter death with the Maryla r Itams 23e or 28e-f shov it writtuel be thelified at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No	J.S. 13. Was Dec If Yes, sp	edent of Hispanic Origin? (becify Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show ha Maulcal Exal it art mail be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: (White
2-0	natur	Completed	15. Decedent's Ed (Specify onfy highest grad			vork done during most of wo	orking	16b. Kind of Business	/Industry
121	filed within Hygiene. other than	фшо	Elementary/Secondary (0-12)	College (1-4or 5+)	PROPR			GROCERY S	TORE
	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Ma	Be C	17. Father's Name (First, Middle, Last)				me (First, Middle,		
Maryland	should be fand Mental B marked of	To	ABRAHAM		GLEICHER	LENA	W. -	HABER	Zip Code) 21042
Mar	ges 1 and 2 should be filed within 72 hours a to f Health and Mental Hygiene. If item 27 is marked other than "natural", o or other traumatic event, the Madical Eval.		19a. Informant's Name/Relationship (7	IFE)		ss (Street and Number or R SEY HALL DR.,			
re,	es 1 and of Health fitam 27		20a. Method of Disposition	20b. i	Place of Disposition (A	ame of	Date	20c. Location - City or	
Baltimore,	Pages ment of l ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ • 4 ☐ Donation 5 ☐ Other (Specify	C	OLUMBIA ME			COLUMBIA,	
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licen	1HA				SON & BROS	*
			23a. Part1. Enter the disease, or comp	lications that caused the dear		O REISTERSTOW ode of dying, such as cardia		IKESVILLE,	MD 21208 Approximate Interval Between
	Physician	8	shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line.	bowel				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	+ Parkine			21 hrs
	Examine.	ja	Sequentially list conditions, if any, leading to immediate	b. Due to (or a consec		Flatare			241113
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.					
,00	cate be executed obysician and the burial-transit	1 Exa	resulting in death) Last	Due to (or as a consec	quence of):				
38760,	cate b	dical	•	d					
Box 6	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta				23d. Date of de	livery
). B	e death	Completed by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of o				Month	Day Year
P.O.	res that the de signed by the a l be detached f	Phy	9 ☐ Unknown Part II. Other significant conditions or	ontributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
Division of Vital Records,	tuires I n signe	d by	neuodege	7 - 1	sease		1 □ Y	'es 2 □ No 3 □ P	robably 4 Unknown
O S C O	aw require ts been si 2 should t	piete	ASCVD				24a. Was autop	an 24b. Were a	utopsy findings available completion of cause of
E R	The cate ha	Com					perfor 1 ☐ Yes	med? death?	2 □ No
Vita	sician: The law certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	1600	Othor	ath (Check only o		
o	g Physer this eral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		lence 6 Other (Speciow injury occurred	iciry)
sion	andin eath. or: Aft he fun	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		M	1 ☐ Yes 2 ☐ No			
)ivis	or Att	ertifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, street, fact fy)	ory, office	28f. Location (S City or Tow	Street and Number or R n, State)	ural Route Number,
J	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompted in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Ph	ysician: To the best of my known	owledge, death occurr	ed at the time, date and place	e, and due to the	cause(s) and manner a	s stated.
	tha Hc nin 24 i the Fu	Medical	one)	iner: On the basis of examination and manner stated.					
	with To	2	29b. Signature and title of certifier	Millon un	•	9c. License number	, :	29d. Date signed (Mon.	1, 2004
			30. Name and address of per in who	completed cause of death (Itel	m 23a) (Type, Print)	D 200 0	/	^	
_	\		GARY MILLES	10700 Ch	arter Dru	D2662	nk, MI	n'	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Hegistrar's Sign	ature 4				

23d. Date of delivery

Year

11:15 p M

Month Day

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Setifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Typer rint)

Roger Théodore, M.D., St. Joseph Med. Ctr., O'Dea Bldg., Suite 503, Balto., Md.

31. Date filed (Month, Day, Year) State APR 02 2004

29b. Signature and little of certifier

3 Suicide

29a. Certifier

4 Homicide

32. Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

or Attending Physician:

this

funeral

I Director: A d in by the fu

within 24 hours a

To the Funeral C

completely filled To the Hospitel

Be

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Certification:

cal

Certificate of Death 2. Date of Death Month March 26, 2004

4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford 1 Colonial Road

8. Date of Birth (Month, Day, Year) June 25, 1948 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days

1 ☐ M 2 ☐ F Maryland

10d. Inside City Limits 1 ☐ Yes 2 No

10g. Citizen of What Country?

United States

14. Race - American Indian, Black, White, etc.

Specify: white

16b. Kind of Business/Industry

state government

18. Mother's Name (First, Middle, Maiden Sumame)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Colonial Road, Bel Air, Md. 21014

20c. Location - City or Town, State

Bel Air, Md. 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc.

610 W. MacPhail Road, Bel Air, Md. 21014 Approximate Interval Between Onset and Death

25. Was case referred to medical 1 ☐ Yes 2 ☐ No

1. Decedent's Name (First, Middle, Last)

Gregory J. Gaeng

Physician

/Medical

Examiner

27. Manner of Death 1 Natural 5 Pending 2 Accident

investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

recore

29d. Date signed (Month, Day, Year)

ORIGINAL

28b. Time of

		•	For State Registrar	State of Marylan	d / Depa <i>Cer</i>	artment of Ho tificate of D	ealth and M Death		ene2004	10139
	Physicia	an	1. Decedent's Name (First, Middle, Last)	11		LITA	<i>y</i>	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give	street and number)	•	4b. City, Town, or	Location of Death	MARCH	4c. County of Death	11:15 AM
		о .	FUTURERARE !	CHERRYW		. , -	RSTOWN			NORE
	Funeral Director		5. Social Security Number 6. Sec. 215 · 01 · 7969	7. Age (In yrs. I	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	earl. Cour	place (State or Foreign htry)
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. Cit	v. Town or Lo	cation		C 19.0LK		Od. Inside City Limits
	Maryia	tor	MARYLAND BALTIM			sMius				1 ☐ Yes 2 🖪 No
	or 28e	Direc	10e. Street and Number	- Dout		10f. Zip Code	7	10g	. Citizen of What Cour	ntry?
	ms 23e	Funeral Director	V • • • • • • • • • • • • • • • • • • •	THE DRIVE 12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of His	panic Origin? (Spe	acify Yes or No-	14. Race - Americ	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28a-f show early flurry or other treumetic event, the Medical Examer at must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 XNo If Yes, Give Year or Dates:		f Yes, specify Cubar	s, Mexican, Puerto	Rican, etc.)	Specify: White,	etc. HITE
15-0	n 72 h	oletec	15. Decedent's Edu (Specify only highest grad	e com <i>pleted)</i>	(Give	lent's Usual Occupa kind of work done di DO NOT use retired)	uring most of works	ing 16	b. Kind of Business/Inc	dustry
212	giene.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	1 1	MEMAKE			AT Ho	ME
and	otal Hy ed oth ed oth	Be (17. Father's Name (First, Middle, Last)	PULIS			18. Mother's Name	(First, Middle, Ma	iden Sumame) SERVW	E1.(
Maryland	should and Me s mark umetic	2	19a. Informant's Name/Relationship (Ty		19b. Mailin	g Address (Street a	nd Number or Rura	al Route Number, C	City or Town, State, Zip	
Š	and 2 tealth a m 27 is		SUSAN ABBEY	DAUGHTER	9633	sition (Name of	ENTE DE	RIVE, OW	MINGSMILLS	5,MD 21117
Baltimore,	ages 1 ant of H it: If ite y or ot		20a. Method of Disposition 1 MaBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		emetery, cren	natory or other place)	2 42 6	c. Location - City or To	MARYLAND
altii	srmit. F apartme sporter by Injur		21. Signature of Funeral Service Licens	98	22	Name and Address			USRAL CHA	
<u>m</u>	89 5 9	0	232 Bard Fater the disease or comple	Jamotha indicate	Po not ent	FAH COS			KVILLE, M	D 21234 Approximate
	Pinysician	23a. Part1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only organise on each line. Immediate Cause (Final disease or condition disease or condition disease or condition disease or condition disease.)								Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ		312		173002	771 1112	Chise
	Examiner	er	if any, leading to immediate	b. — Due to (or as a consequence of):						
	and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):						
68760,	cate be executed physician and the burial-transit	dicalE								4
	E O R	Medi	IF FEMALE:							
.O. Box	that the death certificed by the attending podetached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1						23d. Date of delive Month	ery Day Year
<u>α</u>	es pe	by	Part II. Other significant conditions con HUPERTENS	n in Part I.			use contribute to the cause of death?			
of Vital Records,	e law requir has been si je 2 should	ompleted						24a. Was an autopsy	24b. Were autop	psy findings available inpletion of
al B		0						performed	d?/ death?	2 ⊠ No
r Vit	S S :=	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	fospital:	ER/Outpatien	t 3□ DOA Othe	26. Place of Death		e 6 □Other (Specify	()
0 u	ding Phy th. : After this funeral o		27. Manner of Death	28a. Date of Injury (Month, Day Year)	jury 28b. Time of 28c. Injury at 2 lnjury Work? 2		28d. Describe how injury occurred			
Division	Attending or death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury : At ho	ome, farm, stre		es 2 No	28f. Location (Stree	at and Number or Rura	l Route Number,
D	itel or irs after rel Dire		4 nomicide	building, etc. (Specify				City or Town, 5		
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier	sician: To the best of my knowner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my opi	a, date and place, a nion, death occurr	and due to the caus ed at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	1-1-1		29c. License			Date signed (Month, I	
•	m		30. Name and address of person who co	Vallan Time	(220) (7	102	8777		3/31/04	
_)		TASNETM A	KHANI 72	20 (TYP8, 1	PARK. H	ध(क्राभगः	AVE,	BALTO M	2001
:-	Sta Registr		APR 0 2 2004	32 Registrar's Sona	ture spor	K				

		1	For State Registrar	State of Marylar		artment of H			ene 2004	10140	
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last)	Hale				2. Date of Death March	28, 2004	3. Time of Death /2:13 . M	
	Examin		4e. Fecility Name (If not institution, give s.	treet and number)	7	4b. City, Town, or	Location of Death	1	4c. County of Death		
	Funeral Director		910110	M 2□ F 7. Age (In yrs.	1ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	plece (State or Foreign intry)	
٥	show	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location PARKVILLE								10d. Inside City Limits 1 ☐ Yes 2 No	
	ith the M or 28a-f	Direct	10e. Street and Number	nore	TAK	10f. Zip Code	22.1	10g	. Citizen of What Cou		
	be filed within 72 hours after death with the Maryland lat lygiene. al dygiene do do defertan "setural", or flems 23a or 28a-f show of other than "natural", or flems 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 Yes 2 Who If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sn, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White		
9500-612	ithin 72 hour ne. nen "netural nedical E.	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	turina most of wor		ib. Kind of Business/li	ndustry	
Maryland 21	uld be filed w fental Hygier rked other th tic event, the	To Be Cor	17. Father's Name (First, Middle, Last) George H	ale	<u>L</u> 17	resmar	18. Mother's Nan	ne (First, Middle, Ma			
	s 1 and 2 shout Health and Millom 27 is ma		19a. Informant's Na Foliationship (Type Muriel Hale					ral Route Number, C	City or Town, State, Zi		
altimore,	Pages 1 nent of H int: If Ite.		20a. Method of Disposition 1 Meurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, crei	matory or otner place	θ)		oc. Location - City or T	own, State	
Balti	permit. Page: Department o Important: If any injury or once.		21. Signature of Funeral Service License		22	2. Name and Addres	is of Facility B	KTIMORE	MD ZIZ	34.	
	#		23a. Part1. Enter the disease, or complications, or heart failure. List only on immediate Cause (Final		th. Do not ent	ter the mode of dying	g, such as cardiad	or respiratory arres		Approximate Interval Between Onset and Death	
~	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consec		tery o) isease			(Oyer)	
4	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
,097	icate be executed physicien and s the burial-transit	icai Exa									
. Box 68	death certif e attending od for use a	Physician/Medi	in the past 12 months?	3c. If yes, outcome of pregn 1	al death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	very Day Year	
s, P.O	The law requires that the de ste has been signed by the a bage 2 should be detached f	by Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac						cco use contribute to	the cause of death?	
Records,	w require been sig should b	Completed t		1 ☐ Yes 2 ☐ No 3 ☐ P							
	n: The la licate has r, page 2								prior to codeath?	ompletion of cause of 2☐-No	
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ion: To Be	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) M M			er: 4 Nursing H	eath (Check only one) Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred		ity)	
ivisio	or Attenditer deatl	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examination	sician: To the best of my kn ner: On the basis of examinand manner stated.	owledge, deat ation and/or in	h occurred at the time vestigation, in my of	ne, date and place pinion, death occu	n, and due to the cau arred at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)	
	To the within 2 To the comple	Med	29b. Signature and title of certifier	Ann		29c. License	e number	290	I. Date signed (Month	, Day, Year)	
	6		30. Name and address of person who co	impleted cause of death (Ite	m 23a) (Type,	Print		IND.	7 1701	1	
	Sta Regist		31. APR 0007. 2004	32. Registrar's Sign	ature An		000,0	VVVV	21200	}	

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			1 _ State	State of Marylar		ent of Health and	Mental Hygie	ne 2004 10141			
			Registrar 1. Decedent's Name (First, Middle, La	241	Certific	ate of Death	Reg.	No			
Physician		an		15DDINGER				Day Year			
	/Medi		4a. Facility Name (If not institution, give		Ab C	ity, Town, or Location of Dea		31 04 11:34HM 4c. County of Death			
	Examir	ıer	Manor Care	- (1)	^	Towson		_			
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.		der 1 Year If Under 24 Hr	8. Date of Birth	BAUTIMORE 9. Birthplace (State or Foreign			
	Director		213-48-3334 1	M 2□F	16 Yrs. Mont	hs Days Hours Min	8. Date of Birth (Month, Day, Ye 3-8-19	58 MARYLAND			
	D >		Usual Residence of Decedent 10a. State 10b. County	100.0	ity, Town or Location						
	aho	ō						10d. Inside City Limits 1 ☐ Yes 2 2 No			
	28a-1	ect	10e. Street and Number	<i>i</i> more	100000	Zip Code	100	Citizen of What Country?			
	death with the Maryland ms 23s or 28s-f show firsts be notified at	Funeral Director	7001 N. Cha	the solv	701.	21204	109.	USA			
	death	nera	11. Marital Status	12. Was Decedent Ever in L	J.S. 13. Was De	ecedent of Hispanic Origin? (Specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,			
9	after or Ita	Full	1 Never Married 2 ☐ Married	Armed Forces? 1 □ Yes 2 □ No If Yes, Give			rto Rican, etc.)	Black, White, etc.			
003	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1019	s 22 No Specify:		Specify: White			
21215-0036	within 72 hours after ene. than "natural", or Ite	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Decedent's U	work done during most of wo	nrking 16b.	. Kind of Business/Industry			
12	withii ene. than	duic	Elementary/Secondary (0-12)	College (1-4or 5+)	Chef	T use retired)	0	water Club			
	be filed with ital Hygiene id other the event, the	Ö	17. Father's Name (First, Middle, Last)	4	UIG	18. Mother's Na	me (First, Middle, Maid	len Sumame)			
lan	lid be lental ked c	To Be	John H H	eddinger	_	Helen	Jacquel	ine Clark			
Maryland	should and Men s marks umatic	-	19a. Informant's Name/Relationship (19b. Mailing Addr	ess (Street and Number or R	ural Route Number, Cit	y or Town, State, Zip Code)			
	1 and 2 Health a em 27 is		Jennifer &	Srocks Jisk	5126 Ro	cks Rd. Picle	sville, m	D 21132			
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		Place of Disposition (Name of place)		Location - City or Town, State			
Ë	Pages Iment of tant: If it jury or o	Į,	*4 □ Donation 5 □ Other (Specify	ENA	WSFUNER	SICHAPEL- 4-	4-04 17	prest Hill, MD			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23s or 28s-f ahow any Injury or other traumatic event, the Moulcal Exercitive mental to notified as angle.		21. Signature of Funeral Service Licen	S00		and Address of Facility	AUTIMORE	, MD 21234.			
	20240		232 Part 1 Enter the disease or core	javioury	EVAN	is funeral	CHAPEL,	8 800 HARFORD RD. Approximate			
			shock, or near failurer List only one cause on each lime.								
	Physician /Medical		disease or condition resulting in death)	a. CIRRONS		12K					
H	Examiner			Due to (or as a consec	quence or).						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):							
	eath certificate be executed attending physician and for use as the burial-transit	Examiner	cause. Enter Underlying that initiated events								
760,	oe exectan a		resulting in death) Last Due to (or as a consequence of):								
687	physic the b	dicai		d							
9 X	ding	/Me	IF FEMALE:	23c. If yes, outcome of pregna	ancv		177				
Вох	atter for u	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 Ectopic		11	23d. Date of delivery Month Day Year			
P.O.	the car	hysi	1 Yes 2 No 9 Unknown	9□ Unknown							
	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physiclan/Med	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?			
Records,	en sig						1 🗆 Yes	2 □ No 3 □ Probably 4 □ Onknown			
OC O	has be	Completed					24a. Was an	24b. Were autopsy findings available			
_		Com					autopsy performed? 1 ☐ Yes 2 ☐				
Viital	siclan: The certificate har rector, page	Be (25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)				
-	Z ≅ 0	2	1 ☐ Yes 2 ☑ No		ER/Outpatient 3		lome 5 ☐ Residence	6 □Other (Specify)			
ň	ling F	lon:	27. Manner of Death ↑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	ury occurred			
Division of	death ctor: / the	licat	2 Accident investigation 3 Suicide 6 Could not be		Ome farm street fact	1 Yes 2 No	29f Location (Street				
<u>≤</u>	after after Direct	Certification:	4 Homicide determined	building, etc. (Specif	(y)	ory, omce	City or Town, Sta	and Number or Rural Route Number, te)			
	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certification in by the funeral director, tely filled in by the funeral director.		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	owledge, death occurre	ed at the time, date and place	and due to the cause	s) and manner as stated			
	n 24 t	Medical	(Check unity 2 Medical Exam	iner: On the basis of examina and manner stated.	ation and/or investigati	on, in my opinion, death occu	irred at the time, date a	nd place, and due to the cause(s)			
0	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After to mpletely filled in by the funeral	Σ	29b. Signature and title of certifier		2	29c. License number	29d. D	ate signed (Month, Day, Year)			
DS7727 4/1/04							11/04				
	W		30. Name and address of person who o	ompleted cause of death (Item	n 23a) (Type, Prin	10	tal D	R-Essex-mD27721			
	CA		31. Date filed (Month. Day Year)	32. Registrar's Signa	1-1 117150	WELLIE II	Ear Rove	T BICK I'VI DAICU			
	Sta Registra	7 7	31. Date filed (Month, Day, Year) APR 02 2004	Serva		No.					

		-	For State Registrar	State of Maryland / De	partment of Health and I ertificate of Death					
	**************************************		Decedent's Name (First, Middle, Last)			2. Date of Death Month D	3. Time of Death			
	Physicia /Medic		Cat	cherine B. Hilley		March 28,	2004 11:57P M			
	Examin	_	4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of Death		c. County of Death			
			Fort WashingtonHos		Ft. Washington		rince George's			
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last birthdom) Yrs	Months Days Hours Min.	8. Dete of Birth (Month, Pay, Year 02/24/192	9. Birthplece (State or Foreign Country) Washington, DC			
	pu *	-	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or	Location		10d. Inside City Limits			
	Maryla	tor	Maryland Prince Ge		ashington		1 ☐ Yes 2, ☐No			
	h with the	al Director	10e. Street and Number 311 Kerby Parkway		10f. Zip Code 20744	10g. C	Citizen of What Country? USA			
980	be filed within 72 hours after death with the Maryland ital Hyglene. ad other than "natural", or items 23a or 28a-f ehow event, the Madical Evaticist moust by notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ※ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
21215-0036	rithin 72 horne. ne. han "natura e Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Completed) (G College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of wor e. DO NOT use retired)	king 16b.	Kind of Business/Industry in Home			
Maryland 2	ed ta b	Be	12 17. Father's Name (First, Middle, Last) William Drury			ne (First, Middle, Maide	en Sumame)			
2	2 should be f and Mental I is marked of aumatic eve	၉	19a. Informant's Name/Relationship (Typ	ne, Print) 19b. M	ailing Address (Street and Number or Ru					
a ≥	s 1 and 2 should f Health and Men item 27 is marke other traumatic		Dean A. Hilley 3rd		Kerby Parkway Ft.					
nore,	ages 1 ar nt of Hea t: If item / or othe		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Circle (Name of cemetery, crematory or other place)							
Baltimore,	permit. Pages 1 and 2 Department of Health s Important; If item 27 is eny injury or other tra		21. Signature Funeral Service Liceasee 22. Name and Address of Facility Geo. P. Kalas Funeral 6160 Oxon Hill Rd. Oxon Hill, Md. 2074							
	Physician /Medical Examiner		23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwoen the death of the condition resulting in death) Due to (or as a ensequence of): Sequentially list conditions, b.							
	(a) 	Ilcal Examiner	Sequentially list conditions, I ary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):	or	discore				
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year			
0	w requires that s been signed b should be deta	d by Pł	Part II. Other significant conditions con	tributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown			
of Vital Records,	The law req	Completed by	Dogenors	live on Mhx	4	24a. Was an autopsy performed 1 Yes 2 12 1	autopsy prior to completion of cause of performed? death?			
/ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?			ath (Check only one)				
1	this al di	2	1 Yes 2 No	ospital: 1 Inpatient 2 ER/Outpa		flome 5 Residence 28d. Describe how in				
on o	ling Afte fune	tlon:	27. Manyler of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Tim (Month, Day Year) Inju		200. Describe now in	quiy occurred			
Division	l or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examinations)	sician: To the best of my knowledge, oner: On the basis of examination and/of and manner stated.	leath occurred at the time, date and place or investigation, in my opinion, death occurrence	e, and due to the cause urred at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)			
	To the To the	Me	29b. Signature and title of certifier		29c. License number	29d. I	Date signed (Month, Day, Year)			
			Men	e.m.s	224020	Md 3/2	29/04			
	10		30. Name and address of person who co Moti Koul, M.D. 44	mpleted cause of death (Item 23a) (Ty 67 Old Branch Ave	vpe, Print) . Suite 203 Temple	Hills, Md.	20748			
-	St: Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Spark					

			For State Registrar	tate of Mar	yland / Depa <i>Ce</i>	artment o	f Health a of Death	and Mentai F	lygiene 2 (004 10143	
			Decedent's Name (First, Middle, Last)					2. Date of Month		3. Time of Death	
	Physicia /Medic	al	William Joseph Hend		r.				29, 2004		
	Examin		4a. Facility Name (If not institution, give stre				n, or Location of			y of Death	
			814 Stone Haven Dri			Jarr	ettsvil			arford	
	Funeral		5. Social Security Number 6. Sex	2□F 7. Age (In yrs. last birthday) Yrs.		ys Hours	Min. 8. Date of (Month, May 9	Day, Year) 1937	9. Birthplace (State or Foreign Country) Maryland	
	Director		215-34-5206 X	00				May 3	, 1937	riai y i aiiu	
	land ow		10a. State 10b. County	1	0c. City, Town or Le	ocation				10d. Inside City Limits	
	Mary -f sh	ţ	Md. Harford		Jarr	ettsvil	1e			1 ☐ Yes 2 ☐ No X	
	r 28a	rec	10e. Street and Number			10f. Zip Cod	de		10g. Citizen of	What Country?	
	h wit	Funeral Director	814 Stone Haven Dri	ve			21084		Unite	ed States	
	deat	ner	The state of the s	Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent	of Hispanic Ori Cuban, Mexicar	gin? (Specify Yes or n, Puerto Rican, etc.)	No- 14. Ra Bla	ce - American Indian, ick, White, etc.	
9	or Ite	F		1 XYes 2 No	1955	1 Yes 2	No Specify:		Speci	6.0	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show fra Morical Evartiner innst Le ricitified at	d by	3 Widowed 4 Divorced	Year or Dates: to		X			16h Kind of 5	white Business/Industry	
7	nati	Completed	15. Decedent's Educati (Specify only highest grade co	on ompleted)	16a. Dece (Give	dent's Usual Oc kind of work do DO NOT use re	ccupation one during mos otired)	t of working	100. Kind of E	susiness/industry	
12	withir ene. than	ᇤ	Elementary/Secondary (0-12)	College (1-4or 5+)				hnician	commun	nications	
	filed Hygi other		17. Father's Name (First, Middle, Last)					er's Name (First, Mid	dle, Maiden Suma	me)	
an	d be ental kad c	То Ве	William Joseph Hend	erson, S	r.		F1or	ence Eliz	abeth Bar	rns	
Maryland	12 should be filed within "h and Mental Hygiene." I s markad other than "I raumatic evant, It a Mes	-	19a. Informant's Name/Relationship (Type,		4			er or Rural Route Nu			
	alth a		Jean Henderson/wife		81	4 Stone	Haven	Drive, Ja	rrettsvi	lle, Md. 21084	
Ĵ.	itam othe		20a. Method of Disposition	- Ctata	20b. Place of Disp cemetery, cre	osition (Name o matory or other	place)	Date	20c. Location	- City or Town, State	
Ë	Page Thent cannot int: If		1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)	oval from State	Bayview	Cremato	ry	3/31/04	Baltin	nore, Md.	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or Items 23a or 28a-f show may injury or other traumatic event, It a Marical Examinet must be radiited at once.		21. Signature of Funeral Service Licensee		2	2. Name and Ad Schimu	ddress of Facili	eral Home	of Bel A	Air, Inc.	
<u> </u>	89 E 29		610 W. MacPhail Road, Bel Air, Md. 21014								
н			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death								
5	Physician		Immediate Cause (Final disease or condition	MYI	ELOFIR	ROSI	S			2 YEARS	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
	LAMITIME		Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):						
	ed isit	nine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or,						
	xecut and al-trar	Examiner	that initiated events c resulting in death) Last	Due to (or as a	consequence of):						
760,	death certificate be executed eattending physician and of for use as the burial-transit	calE									
687	ficate p phys as the		u								
Box	leath certifical attending phy I for use as th	2	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of 1□Live birth 2		⊒Ectopic pregn	2504			ate of delivery	
m.	death e atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at til		Other (specify			_ M	onth Day Year	
P.0	that the ed by th detache	hys	9 🗆 Unknown								
	Se Cla	by	Part II. Other significant conditions contri	outing to death but	not resulting in the	underlying cause	e given in Part I			atribute to the cause of death?	
ord	w requires been sign should be	ted	Congesteur	e nea	81 Jac	lure		<u>'</u>	Yes 2 No	3 Flobably 4 Donklown	
Ö	aw as b	Completed	V					24a. V	utopsy	Were autopsy findings available prior to completion of cause of	
H H	ate T	S						1 🗆 Ye	erformed? s 258No	death? 1 Yes 2 No	
of Vital Records,	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	pital:			26. Place Other:	e of Death (Check or	ly one)	•	
of	this ald di	L _o	1 Yes 2 No	1 🗌 Inpatient 28a. Date of Injury			. 4 INI	ursing Home 5 54 P	esidence 6 Ot be how injury occu		
UQ.	fter fter	- Lo	1 Natural 5 Pending	(Month, Day	Year) Injury		Injury at Work? 1 Yes 2		50 11011 111/317 5000		
Division	Attanding or death.	lica	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injur	y - At home, farm, s			28f. Locatio	n (Street and Num	ber or Rural Route Number,	
Σ	after after Dire	Certification:	4 Homicide	building, etc.	(Specify)			City or	Town, State)		
,	spita nours neral	aC	29a. Certifier 1 Certifying Physic								
	To the Hospital or Attandi within 24 hours afler death. To the Funeral Director: A completely filled in by the fu	ledical	one)	and manner state				an occurred at the th		, and due to the cause(s)	
	To t To t	Σ	29b. Signature and title of pertifier	5	M.T.	_	cense number	7-		ed (Month, Day, Year)	
			M. Sena	sallar			455		03	-30-2004	
,	141		30. Name and address of person who com				, –	AILAM	NA	2 (01)	
	1 1		31. Date filed (Month, Day, Year)	32 Registrar	·	ITE =	700,	BELAIR	1011)-	21017	
	St: Regist	ate rar	APR 0 2 2004	Deser	~ 4	In .	//			/	

State of Maryland / Department of Health and Mental Hygiene 200410144 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 10:05 P M William Franklin Irwin 2004 March 31. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Stella Maris Hospice Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year)
Nov. 6, 1932 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F Yrs 71 Maryland 212 28 6741 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County in then "natural", or items 23s or 28s-f show the Medical Examinar must be nutified at 1 XYes 2 ☐ No Director Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 USA 5429 Force Rd. Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1950/54 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Superintendant Construction 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be h and Mental h Elizabeth Heiser William G. Irwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If item 27 is 5429 Force Rd. Baltimore, Maryland 21206 Edith E. Irwin (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State injury or Department Important: If any injury or Parkwood Cemetery 4/5/2004 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Fruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature of Funeral Service Licensee Durfouste Tim1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LUNG CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Examiner burial-transit Due to (or as a consequence of): the attending physician the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 90 3 ☐ Probably 4 X Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed? The 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 V Other (Specify) HOSPICE Certification: To 1 ☐ Yes 2 ☒ No this. 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Hospital or Attending 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No М 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1. _ 043721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. TARIO MAHMOOD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 02 2004

ORIGINAL

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

Records,

of Vital

Division

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		•	For State Registrar	Olale of	war y tarr	•	tificate of l			g. No.	10145
f			Decedent's Name (First, Midd	fle, Last)					2. Date of Death		3. Time of Death
	Physicia /Medic		tamela	Hnn		ger			Month 3	26 200	4 3:00P.M
	Examin	er	4a Facility Name (If not institution	()	nber)	2010		r Location of Death		4c. County of Dea	imort
H	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		rthplace (State or Foreign
	Director		212-50-0128	1□M 2XF		57Yrs.	Months Days	Hours Min.	6-20-	46 Ma	Ryland
	and w		Usual Residence of Decedent 10a. State 10b. Count	у	10c. Cit	y, fown or Lo	cation				10d. Inside City Limits
	be filed within 72 hours after death with the Maryland Hygiena. Hygiena Hygiena do ther than "natural", or items 23e or 28a-f show do ther than "natural", or items 23e or 28a-f show event. It at Medical Exactiner must be notified at	φ	HI MO	1 Ui		Ka	hulu	i			1 ☐ Yes 2 X No
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	s 23e	ral	472 Kau	lang	St.	C 42 1		6732	pocity Vos or No-	14. Race - Am	encan Indian
_	fter de r Item iner n	Fune	11. Marital Status 1 □ Never Married 2 □ Ma	Armed For	dent Ever in U. rces? 2 X No		1.0	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Wh	
2	ral', o	ρ	3 ☐ Widowed 4 ☑ Divorce	d If Yes, Giv Year or Da	e/ ates:		1 ☐ Yes 2 ANO	Specify:		Specify:)nite.
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2	a filed at Hyg other vent.	BeC	17. Father's Name (First, Middle	, Last)				18. Mother's Nam	e (First, Middle, M	aiden Surname)	
ylar	tic Tke	10 E	Altrod TR	ancis (JUNG			Wee A	ucille	2 Dici	K
Mar	12 shouh and Nama Nama		19a. Informant's Name/Relation	nship (Type, Print) (MORE			Constant Constant	and Number of Rui		City or Town, State,	Zip Code)
<u>၈</u>	s 1 and f Healt item 2 other		20a. Method of Disposition			Place of Dispo	sition (Name of			Oc. Location - City o	r Town, State
E	Pages mant of tant: If i		1 Burial 2 Cremation 4 Donation 5 Other	i 3 □Removal from 5 (Specify)	State FUA	NO FIX	patory or ather place	PEL + 3-3	50-04.7	OREST	thur, mas
gall	permit. Departm Importa eny inju		21. Signature of Funeral Service	e Licensee			. Name and Addre	SS OVANIE PI	Dimon	ium mo	21093
Ц	80 E B B		Tymbelly	4. 2auri	olly	PEI	ACEFUL AL	LTERNAT	TIVES FU	NERAC+C	PEMATION CIE
			23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final	st only one cause on e	ach ne.		1/100-	O- A	ciclen-	+	Interval Between Onset and Death
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	ed sit	iner	Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events	Dile to (or as a ounsed	wanna of):					
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XOS	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?		irth 2 E Feta ant at time of d	ideath 3□	Ectopic pregnancy Other (specify)	1		23d. Date of do Month	ыvery Day Year
j	that the de sed by the a detached t	hysi	1 □ Yes 2 🗹 No 9 □ Unknown	9□ Unkno		-					
ທ໌ ກ	The law raquires that the ste has been signed by th bage 2 should be detache	by P	Part It. Other significant condi	tions contributing to de	eath but not res	ulting in the u	nderlying cause giv	ren in Part I.			to the cause of death?
Vital Records,	w raquires that been signed I should be det										Probably 4 Dunknown
Ç	e law has b	Completed							24a. Was an autopsy perform	ed? prior to	autopsy findings available completion of cause of
E E			25. Was case referred to medic	cal				26. Place of Dea	1 ☐ Yes 2. th (Check only one		s 2/2 No
	ıysicie iis cert direct	To Be	examiner? 1 ☐ Yes 2. ☑ No	Hasnitals	npatient 2	ER/Outpatier	nt 3 DOA	000		nce 6 Other (Sp	ecify)
n ot	ng Ph fter th naral		27. Manner of Death 1 ☑ Naturat 5 ☐ Pend	ding 28a. Date of (Mont	of Injury th, Day Year)	28b. Time of Injury	Wor	rk?	28d. Describe how	w infury occurred	
Division	or Attending Physician: siter death. Director: Atter this certific in by the funaral director.	icati	2 Accident inves 3 Suicide 6 Coul		of Injury - At h	ome farm str	M 1 []	Yes 2 □ No	28f. Location (Stre	eet and Number or F	Rural Route Number,
<u> </u>	after after I Direct	Certification:	4 ☐ Homicide dete		ng, etc. (Speci		oot, taotory, omoo		City or Town,	State)	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funaral di			ying Physicien: To the el Examiner: On the ba							
	the H hin 24 the F mplete	Medical	one) 29b. Signature and little of certifications	and man	ner stated.						
	5 1 × 1 0		Signature and the or certification	Attoubi	nephy	Ciere	m Dr	3142	2 /	larih -	9 2004
	h		30. Name and address of person	on who completed caus	se of death (Iter	n 23a) (Type,	Print)	1.00	30	11:	2/03/2
	Ü		XIAO 2res	v 5601	Loc	h Ro	2von (31	UU 30	s Ba	MATH	4(287
	Sta Regist		31. Date filed (Month, Day, Yes	04 Seng	legistrar's Signa	g a	oaks				nth, Day, Year) 9 2004 2(239
				·		- /					

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2:25 PM JOHN EDWARD JACOBS MARCH 2004 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY BALTIMORE HARBOR HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months **X**☐ M 2☐ F 85 Director July 4, 1918 Tennessee 215-14-5090 filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Items 23a 201 North Crain Highway 21061 Funerai <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: White 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Menial Hygiene. Important: If Item 27 is marked other than *ne any injury or other traumatic event, Ite Media once. Elementary/Secondary (0-12) College (1-4or 5+) 10 Machinest Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bernard Frederick Jacobs Theresa Stallings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Frances Jacobs / wife 201 N. Crain Highway Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 3/30/04 Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. Mark a. Vaneure 101357 1 Second Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CONGESTINE HEART FAILURE years /Medical Due to (or as a consequence of): **Examiner** MORE THAN CORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DISGASE Examiner Due to (or as a consequence of): 4 YEARS Hospital or Attending Physician: The law requires that the death certificate be executed As hours after death.

Funeral Director: After this certificate has been signed by the attending physician and siely filled in by the funeral director, page 2 should be detached for use as the burnar-transit siely filled in by the funeral director, page 2 should be detached for use as the burnar-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 No Probably 4 Unknown RESPIRATORY FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 (Xinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCH 25, 2004 MD RESOUO h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENTER, 3001 SOUTH HANDVER ST, BALTIMORE, HARBOR HOSPITAL THAHILA AHAMED 31. Date filed (Month, Day, Year) APR 02 2804 \$2. Registrar's Signature State metr Registrar

Registrar DHMH 17 Rev 1/200 ouks!

			1 - State Registrar	State of Mar		artmen rtificate				ental Hy	giene 2	004	10148
	Physici		1. Decedent's Name (First, Middle, Last) Francis			ν	ب. هـ			2. Date of De Month	Day	Year Z.064	3. Time of Death 5. 46 PM
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City,	Town, or	Location of	of Death			inty of Death	3. 761
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Maryland 21215-0036	be filed within 72 hours aftertal Hygiene. Id other then "natural", or leavent, I'm Mudical Exertal.	a l	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle,	, Maiden Sun	name)	
<u>a</u>		To B	Joseph C. Mason	n				Eliz	zabet	th Bui	ndy		
ary	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Maili	ng Address	(Street a					wn, State, Zip	Code)
Σ	1 and 2 Health em 27 i		Geroge W. Mason	- Brothe		Koko		ane	Balt	to., I	MD 21:	216	
Baltimore,			20a. Method of Disposition 1. ■ Burial 2 □ Cremation 3 □ R	emoval from State	20b. Place of Dispo cemetery, crei		thar alaa	oria	Da	ite		on - City or To	wn, State
Ë	tmen tant: tant:		*4 □ Donation 5 □ Other (Specify)		Mparktic	,,,,,	PICIN	JI Ia.	4 /	2/04	Laure	1, MD	
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funer Service icens	n W	2.5 2.5	01 G	d Addres WYN I	ns Fa	Nut alls	ter F Pkwy	unera . Bal	l Home to., !	es,Inc. MD 21216
ē			23a. Part T. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the cause on each line.	ne death. Do not en	ter the mode	e of dying	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
	Physician	ì	Immediate Cause (Final disease or condition	Ruptu	wed	Aor	ta.						Onset and Death
	/Medical Examiner		resulting in death)		consequence of):								
	Examine		Sequentially list conditions, if any, leading to immediate										
	pe disit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):								
	be executed sician and burial-transit	хап	that initiated events resulting in death) Last	Due to (or as a	consequence of);								
8760,	ate be ex hysician the buria				,								
687	phys phys s the	dlcal	0										
Box (death certificate be executed e attending physician and nd for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir	Fetal death 3	Ectopic pre						Date of delive Month	ry Day Year
0	the che	hys	9 🗆 Unknown	9□ Unknown									
of Vital Records, P	sign d be	by	Part II. Other significent conditions con	tributing to death but	not resulting in the u	nderlying ca	ause give	n in Part I.			obacco use c Yes 2 □ No		e cause of death? ably 4 Dunknown
တ္တ	S S S	Completed								24a. Was		b. Were autop	sy findings available
æ	0 - 0	ШО								autor perfo	ormed?	death?	npletion of cause of 2 ☐ No
ta	ian: Thi rtificate ctor, pag	a)	25. Was case referred to medical					26. Place	of Death	Check on c		1 1 103	2 140
>	ysic is ce direc	To B	examiner? 1 🗹 Yes 2 🗆 No	ospital:	2 X ER/Outpatier	nt 3 🗆 DO	A Othe					Other (Specify)
0	iding Phy th. : After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	(ear) 28b. Time o	f 2	8c. Injury Work	at	28	d. Describe I	now injury oc	curred	
Ö	Attending it death.	atle	2 Accident investigation		, , , ,	М		res 2□N	No				
Division	i Sige	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, str (Specify)	eet, factory	, office		28	If. Location (S City or Tov		mber or Rural	Route Number,
	Hospital 24 hours a Funeral E letely filled	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of ser: On the basis of early manner state	xamination and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, ar th occurred	d due to the	cause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b/ Signature and title of certifier	11111		29c.	. License	number			29d. Date sig	ned (Month, L	Day, Year)
	1		11101	XIIIIL	人	1	00	597	18		M. 1	2 2	2004
	1		30. Name and address of person woo co	m ted cause of dea	th (Item 23a) (Type.	Print)	,		1 0		arch	2.7 5-	the Consent
)		Richard Str	m ted cause of dea ilka M 32. Registrar's	O. Ilnius	rsi to	1 1	Man /	mud !	reducal	Conter	Balt	mus MI)
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			Please For State Registrar	State of Ma		/ Depa		of He	alth and		/gien	_		149
	Physicia /Medic	al	Decedent's Name (First, Middle, La ROBERT LEE L	EWIS			4b City T	own ord	ocation of De		eath D. 1, 2	ay Yea	3. Tim-	of Death
	Examin Funeral	er		CE Sex 7. Age	e (In yrs. las			OWSON 1 Year	If Under 24 H	rs. 8. Date of B	irth Day Year	BALTI 9. E		te or Foreign
,	Director		215-14-5695 Usual Residence of Decedent 10a. State 10b. County	1□ M 2 X F	81 10c. City, 1	1				SEPT.	3, 19	22	VÁ	City Limits
12:(24	death with the Maryland ems 23e or 28a-f show ir must be notified at	Director	MD NA 10e. Street and Number			BALTU	MORE 10f. Zip (Code		_	10g. C	citizen of What		es 2□No
April 1, 2004 1;	after death wit or Items 23a o	Funeral	5101 BELLEVILL 11. Marital Status 1 Never Married 2 Married	E AVENUE 12. Was Decedent Armed Forces? 1 Xes 2 1 If Yes, Give		1	Vas Decede f Yes, speci			(Specify Yes or Nerto Rican, etc.)	lo-	USA 14. Race - Al Black, W Specify: A		,
n / 1	within 72 hours ane. than *natural', no Medical Esa	Completed by	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr	Year or Dates: ducation rade completed)		16a. Deced (Give life. L	lent's Usual kind of work DO NOT use	l Occupat k done du e retired)	ion ring most of v	vorking	16b.		MERICAN	
73	be filed with tal Hygiene. d other than event, It a	Be	Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Las	College (1-4or 5	541		LETTER			lame (First, Middl	le, Maide		SERVICE	
Lewis Maryland	12 should the nand Ment 7 is marked traumatic	2	SAMUEL LEWIS 19a. Informant's Name/Relationship							HETTIE LE	ber, City			
Rabert 1	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is marked other than any righty or other traumatic event, II a Ma once.		DOROTHY R. LEWIS (W 20a. Method of Disposition 1 XBurial 2 Cremation 3 1 4 Donation 5 Other (Spec	□Removal from State	20b. Plac	ce of Dispo netery, cren	Sition (Nam natory or oth REST V	e of her place		ALTIMORE, Date /04	20c.	Location - City	or Town, State	
Balt	permit. Departn Imports any inju		21. Signature of uneral Service Lice 23a. Part 1. Enter the disease, or corshock, or heart failure. List only	My C	d the death.		. Name and 638 N. er the mode	GILM	OR STREE	WYLIE FUN BALTIMO iac or respiratory	RE. M		21217 Approxi	
•	Physician /Medical Examiner		shock, or heart failure. List onf Immediate Cause (Final disease or condition resulting in death)	a. Due to (aras	100	50			Auc				Onset a	Between nd Death
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68760,	leath certificate be e attending physician for use as the buria	ā	IF FEMALE:	d										
P.O. Box 687	Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant al 9 □ Unknown	2 Fetal d	eath 3	Ectopic pre Other (spe					23d. Date of Month	delivery Day	Year
	w requires that been signed b should be deta		Part II. Other significant conditions	contributing to death b	out not resulti	ing in the u	nderlying ca	ause give	n in Part I.			o use contribute		of death?
of Vital Records,	ician: The law r certificate has be ector, page 2 sh	Completed								1 Yes	opsy formed? 2	prior death		igs available of cause of
		on: To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No 27. Manner of Death 1 ☑ Natural 5 □ Pending	Hospital: 1 Inpation 28a. Date of Inju (Month, Da	ury 2	R/Outpatier 8b. Time o Injury		A Other	4 Nursin	g Home 5 Re 28d. Describ	sidence		pecify)	OSPICE
Division	al or Attending s after death. al Diractor: Afte	Certification:	€ Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of In	ijury - At hom tc. (Specify)	ne, farm, str			BS 2 NO	28f. Location City or T		and Number or ale)	Rural Route	lumber,
	To the Hospital or Attend within 24 hours after death To the Funeral Diractor: completely filled in by the	Medical (Physician: To the best eminer: On the basis of and manner st	of examinatio		vestigation,		nion, death o		e, date a		due to the cau	
	17	W	30. Name and address of person wh	huy K	death ytem 2	23a) (Type,	Print)	175	705	. Chale	Ap	ri(1	, 200 O.A. W.	14
70,	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regist	ar's Signatu	Ire A	9 6	boar	the state of		- 3/	·		21204

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH Pay " 2004 **Physician** 9:55 Genevieve A. Larson /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Center Baltimore Saint Joseph Medical Towson If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jun 21, 1921 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M 2 🗹 F 82 Yrs. Illinois 323-18-5530 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Exemple or must be notified at 1 Yes 2 No MD Baltimore Towson Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 721 Camberley Circle, Apt. B4 United States Completed by Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: within 72 hours after 1 Neyer Married 2 Married 1 ☐ Yes 2 ☑ No 0 Baltimore, Maryland 21215-0036 Specify: White 3 ₩idowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bakery Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If itam 27 Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Bakery Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown Lewen Stephanie Stellman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard Larson/Son 905 E. Belvedere, Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Apr 1 rtment of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department Important: If any injury or once. Beltsville, MD Chesapeake Crematory 2004 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service/Licensee permit. 22. Name and Address of Facility Funeral Alternatives 8717 Green Pastures Drive Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR THROMBOSIS **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burral-transit Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be be-Box 68768 physicien Physician/Medical the Se IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year jo in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No certificate 1 Yes 2 XNo 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo 2 this 28a. Date of Injury (Month, Day Year) After the 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral D 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier rella mo D 41410 30. Name and "ddre's of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND 21204 7601 OSLER DRIVE, JOGINDER P. MEHTA M. D. . 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 2 2014 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Ella Monroe 3 2004 28 9:10a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NA Joseph Ritchie Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 5 12 35 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 212 F 68 Yrs. 231-44-2762 **Director** Va. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.
It of Health and Mental Hygiene.
It items 22 for marked other than "natural", or items 23e or 28a-f show or other traumatic event, the featings must be notified as 1 X Yes 2 □ No Director NA Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21212 Funeral Richwood Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼No Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital 12th grade 17. Father's Name (First, Middle, Last) CNA 18. Mother's Name (First, Middle, Maiden Sumame) Monroe Alfonso Pollard Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If tiem 27 Is. any injury or other trau P.O. Box 104, Stevens Church, Va. Mother Mary P. Monroe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 \(\mathbb{R}\) Burial 2 \(\subseteq \text{Cremation} \) 3 \(\subseteq \text{Removal from State} \) 4 \(\subseteq \text{Donation} \) 5 \(\subseteq \text{Other} \((Specify) \) 3-31-03 Burington, Va. Beth. Bapt. Ch Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 I and 1101 E. North Ave. ane March F. H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** probable cancer lung weeks /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Due to (or as a consequence of): the attending physician Physician/Medical as the l 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4 Pregnant at time of death 5 Cther (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ psychosis 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 1 Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Dether (Specify) + CS PIC2 1 Yes 2 No 2 3□ DOA o 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospital or Attending 5 Pending investigation 1 Natural (1) death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ပ 124170 (A) M 2004 30. Name and address of person o completed cause of death (Item 23a) (Type, Print) NE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

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Maryland 21215-0036

altimore,

To the Hospital

filed within 72 hours after death with the Maryland

Hygiene.

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	43	/sic led ami	ian ical iner	-
Division of Vital Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed	Director: After this certificate has been signed by the attending physicien and	in by the funeral director, page 2 should be detached for use as the burial-transit	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Oate of Death 3. Time of Death Physician Month Day Vincent Macaione Jr. MARCH 28 2004 4:50P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VA MARYLAND HEALTHCARE SYSTEM PERRY POINT CECIL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 212-50-3588 Director 57 26, 1946 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 9104 Thistledown Ct. u. s. A. 21117 Funeral 12. Was Decedent Ever in U.S. Armed Forces? or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No1964 -If Yes, Give Year or Dates: 1967 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ₺ Divorced 1967 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Mechanic Vending Machines les 1 and 2 should be filed vol Health and Mental Hygie of Health and Mental Hygie If item 27 Is marked other to other traumatic event, Its 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vincent Macaione Sr. Irene Armetta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Hammond-Paulus (ex-wife) 2336 Glen Rock Rd., Glen Rock, Pennsylvania 17327 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date armil. Pages 1 epartment of H nportant: If iten ny injury or oth 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gardens 4/2/2004 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Dicense 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset and Death Immediate Cause (Final HUNTINGTON'S CHOREA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: attendir 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No 24a. Was an page 2 autopsy performed? Yes 200 No 1 Yes Certification: To Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director 6 Could not be 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38950 MARCH 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANUEL RAMOS, M.D., VA'MARYLAND HEALTHCARE SYSTEM, PERRY POINT, MD. 21902 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		For State Registrar 1. Decedent's Name (First, Middle, La	ist)	Ce	rtificate of		2. Date of Deat	th	3. Time of Death
nysicia		Bernadette Regina	a Nitz				Month MARCH		
Medica xamine	_	4a. Facility Name (If not institution, give	re street and number)			r Location of Death	4c. County of Death A 8. Date of Birth (Month, Day, Year) Feb 20, 1920 10d. Inside City Limits 1		
		Good Gamar	itan Hos	pital	bai	timore)	NA	
neral ector		220-07-0329	Sex 7. Age (II 1 ☐ M 2 ☑ F	h yrs. last birthday 84 Yrs.	Months Days	Hours Min.	(Month, Day,	Year)	Country)
-	-	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Lim
er must be notified at	ō	MD N/A		Baltimor	e				1 es 2 □
pod	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	t Country?
	a D	6401 Loch Raven B	Blvd., Apt 3	34	21239		1	United St	tates
5	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin? (Spec an, Mexican, Puerto R	cify Yes or No-		
8	린	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:	,		
event, the medical exal	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:					Wh	
- The	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	edent's Usual Occup e kind of work done	pation during most of workin d)	g		ess/industry
	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	1	naker	<i>D)</i>		JWII IIOIIIE	
		17. Father's Name (First, Middle, Lasi	*1	Homer	maker	18. Mother's Name	(First, Middle, M	Maiden Sumame)	
	Be	Santee Augustus							
100	ဥ	19a. Informant's Name/Relationship		19h Mail	ing Address (Street				te Zin Code)
		Ms. Joanne Nitz/I			•				
	-	20a. Method of Disposition	_		osition (Name of ematory or other place		-		
5		1 ☐ Burial 2 ☑ Cremation 3	THE HOLD STATE		ematory or other plac ike Cremat	1 4.4	or 1		
		* 4 □ Donation 5 □ Other (Speci							
DUC.		21. Signature of Funeral Service Lice	1) Moo						
Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		22a Part 1 Enter the disease or cor	nolications that caused the	death Do not er				and the second section of the section of the second section of the section of the second section of the section of th	Section 1
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each line.	NEUMINIA	iter the mode or dyn	ig, soon as cardiae or	respiratory arre	331,	Interval Between
an		Immediate Cause (Final disease or condition resulting in death)							
al er		1	Due to (or as a co	onsequence of):					
	_	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a c	onsequence of):					
╗	Examiner	cause (Disease or highly that initiated events	-			•			
	xar	that initiated events resulting in death) Last	C Due to (or as a c	onsequence of):					
	a								
	Sec		d						
	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Date of	f delivery
200	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim		□Ectopic pregnancy □ Other (<i>specify</i>) _	y 		Month	Day Year
	ıysı	9 Unknown	9□ Unknown						
0	y P	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying cause giv	ven in Part I.	23e. Did tot	pacco use contribu	te to the cause of death
2	d by	COPO					1 🖫 Ye	s 2□No 3[Probably 4 Unknown
	Completed						24a. Was a	n 24b. Wer	e autopsy findings avail:
9	Ē						perform	ned? deal	th?
	e Cc	25. Was case referred to medical	1	···		26 Place of Death			Yes 2 No
	o B	examiner?	Hospital:	2 ER/Outpatie	ent 3 DOA Oth	or		-1	Speciful
=	-	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c, Injur	ry at 2			Эр в спу)
-	tlor	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigate	(Month, Day Y	ear) Injury	Wor M 1□	rk? Yes 2.⊡No			
8		3 Suicide 6 Could not determined			treet, factory, office	2	8f. Location (St. City or Town	reet and Number on, State)	or Rural Route Number,
eral di	ertifica		hysician: To the best of n						
eral di	ical Certification;	(Check only 2 Medical Exa							
eral di		(Check only 2 ☐ Medical Exa	aminer: On the basis of ex and manner stated		29c Licens	se number	2	9d Date signed /&	Month Day Year
eral di	Medical Certifica	(Check only 2 Medical Example) 29b. Signature and title of certifier			29c. Licens			. A	-
eral di		(Check only 2 ☐ Medical Example) 29b. Signature and title of certifier	and manner stated	1.	RES			. A	-
completely filled in by the funeral director, pag		(Check only 2 Medical Example) 29b. Signature and title of certifier	and manner stated	i. h (Item 23a) (Type	RES		- 1	MARCH 30	

04-02205 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For State Registrar	State of	Maryland / Dep	artment of Hertificate of I	lealth and N Death		ene2004	10154
Physician /Medical	1. Decedent's Name (First, Josep) As Escility Name (If not ins	Middle, Last) Read ittution, give street and num	PRITC		r Location of Death	2. Date of Death Month MARCH	Day Year 30, 2004 4c. County of Death	3. Time of Death 1:50P.
Examiner		RE NATIONAL F			SVILLE		BALTIMORE	
Funeral Director	5. Social Security Number 376-82-174	6. Sex 1 M 2 □ F	7. Age (In yrs. last birthday 39 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birth	pplace (State or Foreign (ntp) RYLAU
the Maryland 28a-f show putilised at ector	Usual Residence of Deceder 10a. State 10b. C		10c. City, Town or L	ocation LTIMOR	F			10d. Inside City Limits 1 ☐ Yes 2 No
1215-0036 within 72 hours after death with the Maryland ane. than "natural", or items 23s or 28s-f show the Modest Examiner Lans by notified at empleted by Funeral Director	10e. Street and Number	- House	, Ne	10f. Zip Code	234	10	g. Citizen of What Cou	intry?
ler death	11. Marital Status 1 Never Married 2	Armed Ford	dent Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
5-0036 72 hours all natural; or deal Example eted by F	3 ☐ Widowed 4 Div	orced If Yes, Give Year or Dai	les:	1 Yes 2 No	Specify:	11	Specify: W	hite.
21215-00 ed within 72 hos vgjene. Per than "naturatr, the Modeled Completed	(Specify only Elementary/Secondary (C	highest grade completed)	4or 5+) (Giv	e kind of work done of DO NOT use retired BTRUCTIO	during most of work f)			PILE DRIVE CONSTRUCTION
be filed that do ther event, I		()		NOCITE	18. Mother's Nam	e (First, Middle, M	aiden Sumame)	201001KUCI 1010
Maryland d 2 should be filt th and Mental Hy 7 is marked oth traumatic event To Be	19a. Informant's Name/Rei	· PRITCH ationship (Type, Print)		ing Address (Street a	Lill) as	A KEA.	City or Town, State, Zi	p Code)
- C = N L	RALPH L. P 20a. Method of Disposition	RITCHARD-1	ATHER 902 20b. Place of Disp	5 Scotts	HAVEN	DR., BA	CTIM ORE,	MD 21234.
Page:		ation 3 Removal from S her (Specify)	EVANS FU	NELAL CHA	PE1- 4-3	3-04 F	FORESTH	HILYMO
Baltime permit. Pag Department Important: I any injury on once.	21. Signature of Funeral Se	ervice License	A 2	22. Name and Addres	ss of Facility BAL	TIMORE	5,MD ZIZ 800 HARFO	-34.
	23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final	se, or complications that ca List only one cause on ea	esed the death. Do not er	nter the mode of dying	g, such as cardiac			Approximate Interval Between Onset and Death
Physician /Medical Examiner	disease or condition resulting in death)		r as a consequence of):	shot wou	ino			
je je	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	b. Due to (o	r as a consequence of):					,
760, te be executed ysician and be burial-transit	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (o	r as a consequence of);					
6876 tificate be ng physicia as the bu	T	d						
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physicien: The law requires that the death certificate be executed 14 hours after death. Funeral Director: After this certificate has been signed by the attending physicien and telly filled in by the funeral director, page 2 should be detached for use as the burial-transitical Certification; To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live bir	nt at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	rery Day Year
rds, P.O. Indices that the dansigned by the lid be detached days it do by Physical by Phys	Part II. Other significant co	anditions contributing to dea	ath but not resulting in the	underlying cause give	en in Part I.		acco use contribute to	the cause of death?
The law requir						24a. Was an autopsy perform	ed? prior to co	opsy findings available ompletion of cause of
f Vital Relysicion: The sis certificate hidrector, page	25. Was case referred to m	edical			26. Place of Deat	1 (A) Yes 2 one		2 140
of V Physic rithis ce ral direc	examiner? 1 X es 2 No	Hospital: 1 🔲 In			4 Nursing Ho		ice 5 Other (Speci	*/SCENE
On C ding P h. After t funera		28a. Date of (Month		Work	/at ⟨? Yes 2. X No	28d. Describe how	vinjury occurred Shot hims	014
Division of Vital Records, To the Hospital or Attending Physicien: The law requires t within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be a Medical Certification; To Be Completed by	3 X Suicide 6 □ 0	Could not be letermined 28e. Place of building	of Injury - At home, farm, sign, etc. (Specify)		,		eet and Number or Rur State) 580 Ba	al Route Number, Kimirk Noticed
he Hospita n 24 hours he Funeral pletely fillec	29a. Certifier 1 Ce (Check only 2 XMe	rtifying Physician: To the badicel Exeminer: On the bas	pest of my knowledge, dea sis of examination and/or in	th occurred at the tim	ne, date and place,	and due to the cau	use(s) and manner as	stated. to the cause(s)
To the Vithin 2 To the complet				29c. License	number -	290	d. Date signed (Month,	Day, Year)
	► Lig	w. mis		0.	C.M.E.	MA	ARCH 31,200	4
15	30. Name and address of p	erson who completed cause	of death (Item 23a) (Type	111 Penn	Street. 1	Baltimore	e, Maryland	L 21201
State Registrar	31. Date filed (Month, Day, APR 0 2	Year) \$2. Re-	gistrar's Signature	Sports			we and J didle	LA LANGE

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Month **Physician** Charlotte Maile Powell March 26, 09:30 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Genesis Eldercare Hammonds Lane Brooklyn <u>Anne Arundel</u> If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 82 228-14-2966 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner is ust be notified at 1 ☐ Yes 2 No Directo Anne Arundel Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5721 Pope Street 21225 Funeral Rear Unit USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Assembler Electronics it of Health and Mental Hyg : If item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clifford Maile Pages 1 and 2 should Daisy Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Terry Maile / Son 5719 Pore Street Brooklyn, MD 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or c ar 29 2004 1 Burial 2 Cremation 3 Removal from State Stevensville, MD 4 □Donation 5 □Other (Specify) Chesapeake Cremation 21. Signature of Funeral Şervice Licensee 22. Name and Address of Facility Singleton Funeral Home, PA Vanure 1 Second Ave S.W. Glen Burnie, MD 21061 MO1357 23a. Part1. EMer.the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTENOSCE **Physician** PROTIC CANDIOVASCULAN /Medical DUGASH **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, attending physicien Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ DISMISN71A 3 ☐ Probably 4 ☐ binknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Sursing Home 5 Residence 6 Other (Specify) 20 No 2 1 Tes 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Mann o Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital or within 24 hours at To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 21776 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURYON WUNDAR MD 300 (HANOUER ST, BATTOMORE 2122 INDIA MO 32. Registrar's Signatur State Registrar

		1	For State Registrar	State of	Marylan				ealth and N Death	fental Hyg	jiene 10g. No.	2004	10156
			Decedent's Name (First, Middle, Last)							2. Date of Dea Month		Yeer Yeer	3. Time of Death
	Physicia /Medic		Margaret Elizabeth	Pudelk	ewicz					March 3	-	2004	12:58 p M
	Examin		4a. Fecility Name (If not institution, give s 329 Margaret Avenu		ber)			, Town, or SEX	Location of Death		1	County of Deeth	:
	Funeral Director		5. Social Security Number 6. Sex 226–26–7891	M 203F	7. Age (In yrs. 82	last birthdey) Yrs.	If Unde Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, De) Dec. 11	7 (Yeer) 192	9. Birth Cou 1 Vir	place (Stete or Foreign ntry) jinia
1	2	-	Usual Residence of Decedent 10e. State 10b. County		10c Cit	ty, Town or Loc	ration						10d. Inside City Limits
-	show	. 1	10e. State 10b. County Maryland Baltimore		Ess		Janon						1 ☐ Yes 2 ☑ No
	28a-f	ect	10e. Street and Number		100		10f. Zi	p Code			10g. Citi	izen of What Cou	ntry?
3	36 04	٥	329 Margaret Avenu	e			2	1221			U.S	.A.	
	ms 2	Funeral Director	11. Marital Status	12. Was Deced		.S. 13. V	Vas Dece	edent of H	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No-		14. Rece - Ameri Black, White	
2	or ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2	2⊠ No		□Yes	7.0	Specify:			Specify: Whi	te
Ś	tural'	ed b	3 Widowed 4 Divorced	Year or Da	105:	16a. Deced	lent's Usu	Jal Occup	ation		16b. Ki	ind of Business/Ir	
ו מ	n na Madic	Completed	(Specify only highest grade		4or 5+)	(Give	kind of w OO NOT (ork done d use retired	during most of world)	king			
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alla	2 should be filed within 72 hours after death with the manyand and Mental Hygiene. Is marked other than "natural", or Items 23e or 28a-f show aumatic event, the Madical Examination and interest must be notified at	Be	17. Father's Name (First, Middle, Last)						18. Mother's Nam Gracie J				
2 2	1 Men narke natic	ှ	John Bunyon Carter 19a. Informant's Name/Relationship (Ty			19b Mailin	a Addres	s (Street	and Number or Ru				p Code)
2	th and th and th is to traur		Max Pudelkewicz (H)				Avenue, E				
อ์	t Heal them item		20a. Method of Disposition		- 1	Place of Dispo	sition (Na	ame of other place	ce)	Date	20c. Lo	ocation - City or T	own, State
Ē	Page nent o int: If iry or		¹ABurial 2 ☐ Cremation 3 ☐ F ¹ 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from S	STATE !	rdens 0	-			3,2004	Bal	timore,	Maryland
Baltimor	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licens	Rusk	Re-	22	. Name a	and Addre Bri Old I	ss of Facility uzdzinski Eastern A	Funera venue,	l Ho Esse	me, P.A.	land 21221
			23a Part1. Enter the disease, or complessiock, or heert failure. List only of	ications that cane cause on ea	aused the dee	th. Do not ent	er the mo	de of dyin	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		1	srular	a	ccid	lent				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence ol):							
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
ó	an and rial-tra		resulting in death) Last	Due to (or as a consec	quence of):							
9/8	death certificate be executed e attending physician and of for use as the burial-transit	dicai		d									
<u> </u>	entific ding p	/Mec	IF FEMALE:	23c. If yes, out	come of prean	ancv						23d. Date of deli	/ATV
Box	attend for us	Physician/Me	in the past 12 months?	1 Live bi	irth 2 ☐ Feta ant at time of	al death 3	Ectopic Other (s	pregnancy specify)	/			Month	Day Year
Ö.	at the de by the a stached f	hysi	1 ☐ Yes 2 DXNo 9 ☐ Unknown	9 Unkno	own								
S, T	The law requires that the tee by the bas been signed by the bage 2 should be detache	by P	Part II. Other significant conditions co	ntributing to de	eath but not re	sulting in the u	nderlying	cause giv	en in Part I.				the cause of death?
ord	v require been si should I	ted	Hypertension							10			
Vital Record	alawi hasbu e 2 sh	Completed	Giant (ell	arter	itis					24a. Was autor perfo		24b. Were aut prior to c death?	topsy findings available ompletion of cause of
E H									#0 Bt / C	1 Yes	2 X No		2 No
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o		n; To	27. Manner of Death	28a. Date o		28b. Time o		28c. Injur	ry at	28d. Describe			
ion	Attending Physician: r death. ector: Atter this certific. by the funeral director,	atio	1 Natural 5 Pending investigation	(7710.77	.,,	,,	М		Yes 2 □ No				
Division of	or Attending P after death. Director: After t d in by the funera	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place buildir	of Injury - At I	nome, larm, str sify)	reet, lacto	ory, office		28f. Location (. City or To			ral Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1⊠ Certifying Phy	reician: To the	hast of my ka	nowledge deat	h occurre	d at the ti	me date and place	and due to the	cause/-	and manner as	stated.
	To the Hospitel within 24 hours a To the Funeral I completely filled	edicai	(Check only 2 Medical Exem	ying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Leal Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								to the cause(s)	
	To the To the	Me	29b. Signature and title of certifier	M	9,	44.0	2	9c. Licens	se number		29d. Da	te signed (Month	, Dey, Year)
	T		Jeffrey Lance	1/ 49	commen	MD		000	13 (444		HF	oril ly	2004
	10		30. Name and address of person who o	11.			Print)	2 6	ille on c	1.70 3	2.	1-11-	4MD 21093
			31 Date filed (Month, Day, Year)		legistrar's Sign	nature #	10 13	J 14	113 NO. 3	14 Jo	() (LU//7/XV,/	11/2 CIV13
*	Sta	ate	31. Date filed (Month Day, Year) APR 02 20	04 ×	Genera	1 4	- 4	San					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item #20 State par Many larges to Dapar Open test Health and Mental Hygiene 2004; State Registrar Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** /Medical 4b. City. Town, or Location of Death 4c. County of Death Fecility Name (Innot institution, give street and number) Examiner Firthplace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days 1□M 2□F Hours 217-66-5652 Director 73 5-4-30 Va Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iteme 23s or 28s-f ehow ury or other traumatic event, the Medical Examinating the motified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 □ No Directo Md. NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 216 S. Spring Ct USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give 7 Year or Dates: Specify: Black 3 → Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4th grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) Be Smith James Connie Mae Mccov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 S. Spring Court, Baltimore, Md. 21231 Daughter Charlene Perkins Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Garden of Faith

Complete, crempator, or other place)

Garden of Faith

Voshell Mem. Gard Department of H Important: If ite eny injury or ot 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Baltipore, -Dundalk, permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 lady March F.H. East 1101 E. North Ave. and 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset Ind Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of) Physician/Medical Examiner physician and the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes No 24a. Was an page certificate 2 No 1 ☐ Yes director 25. Was case referred to medica 26. Place of Death (Check only one, examiner' 1 ☐ Yes 200 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 70 2 ER/Outpatient 3 DOA SIL 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Natural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dira 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ss of perso, who completed cause of 31. Date filed (Month, Day, Year) 32. Registrar's Sig

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

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2004

			1 - For state unpend Item#23	State of Ma a-c,27,28a-f	HER ME 6830	artment of H	lealth and N Death	Mental Hygi ®•	ene g. No. 200	4 10158
	Physic	an.	1. Decedent's Name (First, Middle, La	st)	_	·		2. Date of Death Month	Day Ye	3. Time of Death
	/Medi		Devin Ch		er Roll			MARCH	25, 2004	0727 A M
	Examir	er	4a. Facility Name (If not institution, giv JOHNS HOPKINS HO			4b. City, Town, or BALTIMO	r Location of Death RE CITY		4c. County of D	
	Funeral		Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day,		Birthplace (State or Foreign
0	Director		210-10-1112	M 2□F	18 Yrs.	Months Days	Hours Min.	Jul 23	1985	Maryland
	Maryland -f ahow		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. toside City Limits
	e Man	ctor	MD N/A		Baltin	nore (ユナイ			1 XYes 2 □ No
	with the a or 28a	Dire	10e. Street and Number	•		10f. Zip Code		10	g. Citizen of Wha	•
	€ 23 €	Funeral Director	3609 Glen	Arms 12. Was Decedent B	4ve ver in U.S. 13.1	2./2 Was Decedent of H		ecify Yes or No-	14. Race - A	American Indian,
9		Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉	lo	f Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black, V	Vhite, etc.
5-003	ours	d by	3 Widowed 4 Divorced	tf Yes, Give Year or Dates:		I□Yes 2X No	Specify:		Specify: 6	slack
215-	in 72 i	olete	15. Decedent's E (Specify only highest gra	de completed)	(Give	lent's Usual Occupa kind of work done of DO NOT use retired	durina most of work	ring	6b. Kind of Busine	ess/Industry
212	e filed within al Hygiene. I other then vent, the We	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Cashie	•		Fast	Food
	s 1 and 2 should be filed within 72 ho I Health and Mental Hygiene, item 27 Is marked othar than "natur other traumatic evant, the Medical	Be	17. Father's Name (First, Middle, Last,	~				e (First, Middle, Ma		
Maryland	should be nd Mental markad c	ဥ	Melville Jos 19a. Informant's Name/Relationship (- Add (C44		onyA		
Ma	lith an 27 is r		Melville Jos					al Route Number, e Baltu		
Je,	of Hea item		20a. Method of Disposition		20b. Place of Dispo				Oc. Location - City	
Ē	Page ment o ant: If ury or		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specif		Kmg Mem			31,04 8	Baltimor	e, MD
Baltimore	permit. Pages 1 a Department of Hee Important: If item any injury or othe		21. Signature of Funeral Service Licer Ronald a. A		22	Name and Addres	s of Facility	ion Fu	neval 14	
15	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each tin	the death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between
			tmmediate Cause (Finat disease or condition resulting in death)	Cardiac A	orhythmia —					Onset and Death
			(Coronary	consequence of): Prtery Dyspla	sia occurri	ing during a	agitation a	nd	
		ner	Sequentially list conditions, if any, leading to immediate		consequence of):					
	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Psychotic						196
60,	icate be executed physicien and s the burial-transit	al E	rosaning in obality sast	Due to (or as a	consequence of);					
68760,	2 4 0	edical		d						
Box	death certific e attending p d for use as f	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outcome of		Ectopic pregnancy			23d. Date of	delivery
	0 0 0	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 1		Other (specify)			Month	Day Year
P.0	The law requires that the de ate has been signed by the a bage 2 should be detached (Phy	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the ur	deriving cause give	n in Part I.	23e. Did toba	cco use contribute	to the cause of death?
Records,	quires that n signed I	d by								Probably 4 Dunknown
000	law requir as been si 2 should l	plete						24a. Was an	24b. Were	autopsy findings available
R		Completed						autopsy performe Yes 2	d? death	to completion of cause of ? es 2 No
Vital	ding Physician: After this certification funeral director.	Be	25. Was case referred to medical examiner?	Hospital: 🔽		24		(Check only one)		
of	Phys rthis ral dii	1: To	1 X Yes 2 No 27. Manner of Death	28a. Date of Injun	28b, Time of		4 Nursing no	me 5 Residence 28d. Describe how		pecify)
ion	Attending Is death.	atlor	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	3 M95 1/10 ay	Year) unknown	28c. Injury Work 1 □ Y	? (es 2 X No	unknown	injury coodings	
Division	I or Attendate deatl	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building etc.	ry - At home, farm, stre (Specify)	et, factory, office		28f. Location (Stre	et and Number or Statel	Rural Route Number,
٥	oital or urs afte eral Dir illed in			nospitai						, Baltimore, MD
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of liner: On the basis of and manner stat	examination and/or inv	occurred at the tim estigation, in my op	e, date and place, a inion, death occurr	and due to the caused at the time, date	se(s) and manner a and place, and d	as stated. lue to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier	1 0		29c. License O.C.N	number	290	. Date signed (Mg MARCH	onth, Day Year)
) Uta	erre)		0.0.1	7 • E		THANCE 2	20, 2004
			30. Name and address of person who	0 4	.0				_	
	Sta	to.	31. Date filed (Month, Day, Year)	32 Registra		nn Street	t, Baltim	ore, Mary	land 212	201
	Registr		APR 0 2 20		. 14 Con	atte 1				

			1 - For Stete Registrar	State of Ma	ıryland	-	rtment of H		nd Me			2004	10	159	
	Physici		1. Decedent's Name (First, Middle, Last) Juanita Fay Russel	1						Date of Deat Month Dril 1		04 Year	3. Time of 4:20	Death a M	
	/Medic Examin		4a. Fecility Name (If not institution, give s 2 Right Wing Drive				4b. City, Town, or Middle 1		Death			unty of Death Ltimore			
5.	Funeral Director		224-18-5704	M 2FLF	(In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Dete of Birth (Month, Dey, March 1	Year) 7 , 191	9. Birth Con 18 Vir	plece (Stete c intry) ginia	r Foreign	
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore		-	Town or Lo							10d. Inside Ci	ity Limits	
	with the	i Direc	10e. Street and Number 2 Right Wing Drive	L			10f. Zip Code 21220				Og. Citizen	of What Cou	intry?		
036	be filed within 72 hours after death with the Maryland all Hygiene. Id either than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event. I'm Medical Examiner must be notified at	by Funeral Director		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ M If Yes, Give Year or Dates:		l:	Vas Decedent of H i Yes, specify Cuba □ Yes 2⊠Xio	ispanic Originan, Mexican, I	in? (Specif Puerto Ric	y Yes or No-	14.	Race - Amer Black, White	, etc.		
21215-0036	within 72 hou jiene. r than "naturi I'n Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		+)	16a. Deced (Give life. L	ent's Usual Occup kind of work done o OO NOT use retired tress	ation during most o	of working			of Business/I	ndustry		
Baltimore, Maryland	m = 0 5	To Be C	17. Father's Name (First, Middle, Last) Franklin Monroe Ro	bbins							rst, Middle, Maiden Sumame) scilla Kirby				
, Mar	and 2 shoalth and 27 is mer traum		19a. Informant's Name/Relationship (Type Edward Russell (Sc				g Address (Street : Fuselage							20	
more	Pages 1 a ent of He nt: If Item ry or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ R: 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cen	netery, cren	sition (Name of natory or other place 1 Mem. Ga		Date oril 3			ion - City or 1 cimore		Land	
Balti	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any njury or other traumatic ed once.	Holly Hill Mem. Gard. April 3, 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral 1407 Old Eastern Avenue, Es										l Home, P.A. ssex, Maryland 21			
	Physician /Medical		23a. Part1. Enter the disease, or compli- spock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused e cause on each line	e. ent	Do not ente	or the mode of dyin	g, such as ca	ardiac or re	espiratory arre	st,		Approximate Interval Bette Onset and I	e ween Death	
8760,	physician and physician and sthe burial-transit	Ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a	STAT conseque	nce of):	NON SI	MALL	CEI	LL WI	N/A (I	ANER	15m	ioN file	
.O. Box 68	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 Fetal d	leath 3 🗆	Ectopic pregnancy Other (specify)				23d.	. Date of delive Month		Year	
۵.	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death bu	it not result	ing in the ur	iderlying cause givi	en in Part I.		23e. Did tob	-		the cause of d		
Il Records,	The law requirate has been page 2 should	Completed								24a. Was an autopsy perform	/	prior to co death?	opsy findings and open of careful	available ause of	
Vital	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No H	ospital:	05	210	2 DOA Othi	0.0		Check only one				=:=	
ion of	ding After	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatier 28a. Date of Injun (Month, Day		8b. Time of Injury	28c. Injun Work	4 Nurs	280	5 X Resider			fy)		
Division	4 - 0 Q	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry - At hom :. (Specify)	e, farm, stre	et, lactory, office		28f.	Location (Str City or Town,		umber or Rur	al Route Num	ber,	
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	dical	29a. Certifier (Check only one) (Check only one) (Check only one)	ician: To the best of ter: On the basis of and manner stat	examinatio	ledge, death in and/or inv	occurred at the timestigation, in my of	ne, date and pinion, death	place, and occurred	due to the ca at the time, da	use(s) and te and pla	d manner as a	stated. o the cause(s)	
	To the To the comp	Me	29b. Signature and office of certifier	raila	m	MÎ	29c. License	number	32	29		gned (Month,	Day, Year)	04	
	V		30. Name and address of person who co	2000	eath (Item 2	23a) (Type, I	Print) 5 - 51 7E 211	UASA	- LUA	M236	>			-	
r a	Sta Registr		31. Date liled (Month, Day, Year) APR 02 20		r's Signatu	re &	Spark	51					-,		

			For State Registrar		epartment of Certificate of		Re	g. No. 200L	
)	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last Genevieve 4a. Fecility Name (If not institution, give	Jean	Royst	er or Location of Death	2. Date of Death Month 3 2	Day Yeer 9 2004 4c. County of Deal	3. Time of Death 1:30a M
	Funeral Director	7.2	5310 Cordelia Av 5. Social Security Number 6. Se 214–38–6335		day) If Under 1 Yea		8. Date of Birth (Month, Day, 11-25-		hplace (State or Foreign
	ne Maryland Ba-f show	ctor	Usuel Residence of Decedent 10a. State 10b. County Md . NA	10c. City, Town o	or Location timore				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural", or itama 23a or 28a-f show my injury or other traumatic event, Ita Medical Exactinar must be notified at anges.	by Funeral Director	10e. Street and Number 5310 Cordelia Ave 11. Marital Status		10f. Zip Code 2121 13. Was Decedent of If Yes, specify Cu		ecify Yes or No-	uSA 14. Rece - Ame Black, Whit	rican Indian,
21215-0036	72 hours after natural', or It	eted by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad	1 Tyes 25 No If Yes, Give Year or Dates:	1 Yes 2 No	Specify:	1		Black
S)	be filed within ital Hygiene. od other than " event, tre Me.	Be Completed	Elementary/Secondary (0-12)	2 yrs. C	ife. DO NOT use retir	18. Mother's Name	e (First, Middle, M		1d.
laryla	and 2 should beath and Mente n 27 is marked ier traumatic e	Tof	Henry 19a. Informant's Name/Relationship (T) Ralph C.			Aslear of and Number or Rura ia Ave., E	al Route Number,		
ē	permit. Pages 1 and 2 Department of Health Important: If Item 27 eny injury or other tra once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)	Removal from State 20b. Place of D cemetery, Woodla	disposition (Name of crematory or other plans) Swn Cem.	(ace) 4-3-	Date 2	Oc.Location-City or Baltimore	Town, State
Bal	Deparition of the control of the con		21. Signature of Funeral Service Licens 22. Part 1. Enter the disease, or compishock, or heart failure. List only o	ications that caused the death. Do not		.H. East		. North Av	21202 7e. Approximate Interval Between
1760,	Physician American and American	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	Due to (or as a consequence of) CAUSCM		Psv28: Psv2		Onset and Death	
P.O. Box 68	The law requires that the death certificate be "xeculed tie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	cy NA		23d. Date of dell Month	iveny Day Year
ords, P	requires that een signed b		Part II. Other significant conditions co	ntributing to death but not resulting in th	he underlying cause g	iven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Vital Record	an: The law tificate has b tor, page 2 s	e Completed	25. Was case referred to medical			26. Place of Death	24a. Was an autopsy perform 1 Yes 2	ed? prior to death? No 1 □ Yes	topsy findings available completion of cause of
o	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2.	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1. Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Tim Inju	ne of 28c. Injury W	then: 4 Nursing Houry at ork? Yes 2 No	me 5 X Residen 28d. Describe how	ice 6 Other (Spectification) occurred	
Divi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		4 Homicide determined 29a. Certifier 1 Certifying Phy	sicien: To the best of my knowledge, o	V [\(\lambda \) death occurred at the	time, date and place.	and due to the cau	use(s) and manner as	stated
)	To the Hi within 24 To the Fu	Medical	29b. Signature and title of certifier	ner: On the basis of examination and/o	or investigation, in my	opinion, death occurr nse number	ed at the time, dat	e and place, and due d. Date signed (Month	to the cause(s)
	Sta Registr	-	30. Name and address of person who con Pich Hall			300	f Addiscu	u Scub	BAG

		For State Registrar	State of	f Marylan	d / Depa	artmen rtificate	t of H	ealth ai Death	nd Menta		ne No. 200	4 1016
Physician /Medical Examiner		1. Decedent's Name (First, Middle, I	RAI			4b. City,	Town, or	Location of	AP	RIL O	Year Year 4c. County of De	01.45
Funeral		Northwest Hospi 5. Social Security Number 6	Sex	er 7. Age (In yrs. I	ast birthday)	Ra If Under Months	nda1 1 Year Days	1stown If Under 2	4 Hrs. 8. Da	te of Birth	Baltimo	ore rthplece (State or Foreig
Director		216-34-9777 Usuel Residence of Decedent 10a. State 10b. County	1□XM 2□F	87	7 Yrs.		Days	Hours		ch 1,1	917	KS 10d. Inside City Limit.
To Be Completed by Financial Director	be completed by runeral Director	MD Balt 10e. Street and Number 4 S. Lake Cour 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest status) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Lawilliam T. Rand 19a. Informant's Name/Relationship	12. Was Dece Armed Fo 1 SYes If Yes, Giv Year or Di Education grade completed) College (1 5+	Red dent Ever in U. rces? 2 \(\sum \text{No} \\ end{ates} 1938-5	isters S. 13. 16a. Decer (Give life. AC.	Was Decedif Yes, specific Yes,	21 Jent of His Jen	Specify: tion uring most of 18. Mother' Sophi	's Name (First ia Schi or Rural Rout	s or No- etc.) 16b. St. Middle, Maid ebener e Number, Cit.	Kind of Busines ate of Men Surname) y or Town, State,	1 Tyes 2 No Sountry? Herican Indian, ite, etc. Thite Sindustry Taryland
permit. Pages 1 and Department of Health Important: If itam 27 eny injury or other transcript.		Grace S. Rand 20a. Method of Disposition 1 M Burial 2 Cremation 3 4 Donation 5 Other (Spe	cify)	State 20b. Pi	lace of Dispo emetery, crer ingto:	natory or on Nat: Nat:	ne of ther place ional d Address)	Date 4/20/0	4 Ar. 1824 Re	D 21136 Location - City of lington, eisterst	VA own Road
Physician /Medical Examiner as the prival-transit pedical Examiner pedical Examiner	ical Exal	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Eart Underlying Cause (Disease or injury that inditated events resulting in death) Last	a. Due to (SER or as a consequ or as a consequ or as a consequ	sence of):							Interval Between Onset and Death
es that the death certific igned by the attending p be detached for use as by Physician/Mer	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition:	1 ☐ Live b 4 ☐ Pregn 9 ☐ Unkno	eath but not resu	death 3		ause give	n in Part I.	.	Be. Did tobacc		Day Year To the cause of death?
The law requirecate has been spage 2 should	complete								24	la. Was an autopsy performed?	prior to death?	utopsy findings availab completion of cause of s 2 XNo
ding Physician h. After this certifu funeral director	900	25. Was case referred to medical examiner? 1	28a. Date of (Mont)		ER/Outpatier 28b. Time of Injury		8c. Injury Work	r. 4 🗍 Nurs	28d. D		6 □Other (Sp.	əcify)
oital or Attending Purs after death. oral Director: After illed in by the funeral Certification.	Certific	3 🗍 Suicide 6 🗎 Could not determine	ed 288. Place buildir	of Injury - At ho	·)				Cit	ty or Town, Sta	16)	lural Route Number,
To the Hospital or Attentivities 24 hours after deat to the Funeral Director: Completely filled in by the Medical Certifical	Medical	(Check only 27) Medical Expose 29b. Signature and title of certifier		isis of examination stated.	ion and/or in	vestigation,	License	nion, death number	occurred at th	29d. C	(s) and manner and place, and du	th, Day, Year)
State Registrar		30. Name and a ress person what a ress person which a ress person w	32. R	e of death (Item	ER	Print)	OBL	OER	MEH		(n 33	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** Sherrill, Sr. Jackson March 28 2004 10:45 P.M. Andrew /Medical 4b. City, Town, or Locetion of Deeth 4c. County of Deeth 4e Fecility Name (If not institution, give street end number) Examiner Future Care Baltmore

If Under 24 Hrs. | 8. Date of Birth | Min. | Month, Day, Year) of Home wood If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Social Security Number Funeral Months Days M 2□F 89 Yrs. 218-10-9200 Usuel Residence of Decedent June 7, 1914 Maryland Director 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County filed within 72 hours after death with the Marylen Hygiens. Hygiens returns "natural", or iteme 23a or 28a-f show ent, Ita Medical Examines mast be incilled at 1 Yes 2 □ No Baltimore Funeral Director MD N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21218 USA Avenue whitridge Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, While, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Stetus 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: Black 3altimore, Maryland 21215-0020 ٥ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ORE Shipbuilder

18. Mother's Name (First, Middle, Maiden Surname) STEVADORE Department of Health and Mental Hygis Important: If them 27 is merked other 1 any injury or other traumatic event, III once. 17. Father's Neme (First, Middle, Last) Be Pages 1 and 2 should be Arthur Duffins IRBNE Rolling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 341 Whotrudge Ave. Baltimore, MD 21218 Virginia Lyles/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Apr 3,04 Randallstown, MD King Memorial Park 22. Name and Address of Facility
Ronard An Grayson Francial Home
108 W. North are. Balls. MD 2:201 21. Signature of Funeral Service Licensee 23e. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Aortic Stenosis Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as a consequence of):

Thus Clevolu Cardio Varcular Disease

Due to (or as a consequence of): **Examiner** Examiner Director: After this certificata has been signed by the attanding physician and d in by the funeral director, page 2 should be datached for usa as the burial-fransit Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Deep verus Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Wes case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and eddress of person who completed ceuse of death (Item 23e) (Type, Print)

Ramph Sapapath 3400 Erdman Are 3. Registrer's Signeture 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

APR 0 2 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Stawart 3:45 a, M dackaleen 30 04 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Reliabilitation Extended care Baltimore
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director 10-11-33 Kentuc Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "netural, or Itams 23e or 28a-f ehow 1 Yes 2 No Be Completed by Funeral Director MD BALTIMORE sterstown 10e. Street and Number 10g. Citizen of What Country? 21136 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Amed Forces? 1 XYes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify If Yes, Give Year or Dates: 3 🗍 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) le marked other than Staff SERGEANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider Ke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sate, Zip Code) 21158 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Ien any injury or other traun k, Westminster James Koberts 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State GARRISON, MD Garrison Forest VA Cometery 4-5-04 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licenses OF TRO, TIMONIUM MA 21093. PEACEFUL ALTERNATIVES FUNERAL+CREMATION COUTER Part 1. Enter the disease, or complications that caused to e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Brain **Physician** UNKnow unknown 1 umor resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: be detached for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 menths? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy performed? res 2 2 No 1 🗌 Yes 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check on y one examiner' Other: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier CHOCK ONLY 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 34359(0110) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lock Raven Boulevard, Baltimore, Maryland 21218 3900 m.D 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month JGENIA ANNE 12:25 AM 2004 MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALTIMORE HERRY WOOD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 22 Yrs. GERMANY Director Usual Residence of Decedent death with the Maryland wohe 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. item 27 le marked other then "naturel", or Iteme 23e or 28e-1 ehov other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No **Funeral Director** Dala BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 13402 21013 SA Manor 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 le marked other then "naturel; or Ite 1 Yes 2 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 OME MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Weller Welle ٥ mil ugene. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Ploute Number, City or Town, State, Zip Code) 13402B Manor -daughter niwa Baltimore, 20b. Place of Disposition (Name of cametary, crematory or other text) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ő permit. Page Department of Important: If eny injury or 4 Donation 5 Other (Specify) BEL 21. Signature of Funeral Service Licens 22. Name and Address of Facility PEACEPUL ALTERNATIVES MOCK AND CREMATION CENTER, 2325 YORK RD. TIMONIUM, MD 23a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one gause on each line. Approximate Interval Between Onset and Death 47HERD SCLEROTIC Immediate Cause (Final disease or condition resulting in death) FREBRO VASCULAR Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4¿☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 1 Yes 2/2/No To the Hospital or Attending Physicien: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 🗌 Yes

Box 68760, of Vital Records, P.O. Division

State Registrar

27. Manner of Death

Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

ASNEEM

5 Pending investigation

6 ☐ Could not be

determined

sueur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALLITANI

28a. Date of Injury (Month, Day Year)

29c. License number

28c. Injury at Work?

1 Tyes

2 🗆 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

1)28575

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

after death.

within 24 hours a To the Funerel I filled

in by the

Medical

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

7220

32. Registrar's Signature

Injury

			1 - For State Registrar		ryland / Dep Ce	ertificate of	lealth and Death	-	Reg. No.	2004	10165	
	Physici /Media		Decedent's Name (First, Middle, La.	orvil	le E. S	Scott		2. Date of De Month MARC	Day	Year 201014	3. Time of Death	
	Examir	er	4a. Facility Name (If not institution, giv Saint Joseph		Center	4b. City, Town, or	Location of Deat		4c. Co	unty of Death Balt	imore	
	Funeral Director		406-16-7132	Sex 7. Age	(In yrs. last birthday 83 Yrs.	/) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h y, <i>Year)</i> 1920	Cot	pplace (State or Foreign Intry) tucky	
	nyland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits	
	he Ma 28a-f s	Director	MD Balt	imore		Baltimo	ore		10a Citizan	-414/5-1-0-	1 ☐ Yes 2X No	
	3a or 3	I Dir	6 Pinewall P	lace		10f. Zip Code 2.1.2	236		USA	n of What Cou	intry ?	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinse must be mailtied as	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nidowed 4 Divorced	12. Was Decedent E Armed Forces? I√ Yes 2 □ No If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	ispanic Origin? (S	pecify Yes or No to Rican, etc.)	14.	Race - Amer Black, White ecify.Whi	, etc.	
21215-0036	within 72 ho ene. than "natur the Medical I	Completed	15. Decedent's E. (Specify only highest gra		(Giv	edent's Usual Occup e kind of work done o DO NOT use retired	durina most of wo	rking		of Business/II		
d 21	filed w Hygier other th		10th 17. Father's Name (First, Middle, Last))	Ass	embler	18. Mother's Nar	me (First, Middle,				
/lan	should be filed vind Mental Hygie transfer other transfer event, Elimetic event,	To Be	William T. S	cott Sr.			Leth	a Salmo	ns			
Maryland	s 1 and 2 should f Health and Men item 27 is marks other traumatic		19a. Informant's Name/Relationship (,		ling Address (Street						
altimore, I	Pages 1 and Inent of Health Int: If Item 27 Iry or other tr.		Philip Scott / 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif		20b. Place of Disp cemetery, cre	1 Locust position (Name of ematory or other place illCemet	(e)	Baltimo _{Date} 2/04	20c. Locat	D 212 ion - City or T timore	own, State	
Baltii	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licer		elly "	22. Name and Addres	ss of Facility Co	_			meofEssex	
	Physician		23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition			nter the mode of dyin	g, such as cardiad	or respiratory ar	rest,		Approximate Interval Between Onset and Death YEARS	
	/Medical Examiner		resulting in death)		consequence of):	TO S S S C ON Storage Sec	ANT 8 Through					
4	and stransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):							
8760,	icate be executed physician and s the burial-transit	dlcalE	(_ d.								
.O. Box 68	death certif e attending id for use as	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d	Date of delive	ery Day Year	
٩.	The law requires that the de ite has been signed by the a page 2 should be detached f		Part II. Other significant conditions of	ontributing to death but	t not resulting in the	underlying cause give	en in Part I.	23e. Did to	N/		he cause of death?	
Vital Records,	nysician: The law require nis certificate has been sig director, page 2 should b	Completed						24a. Was autop perfor	sy		opsy findings available impletion of cause of	
Vita	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital: V		ont all DOA Othe	ac.	ath (Check only o				
Division of	ding Pl	ıtlon: To	1 Yes 2 No 27. Manner of D+a 1 Natural 5 Pending 2 Accident investigation	28a. Dine of Injury (Month, Day	/ 28b. Time	of 28c. Injury	4 □ Nursing H	ome 5 Resid			(y)	
Divisi	To the Hospital or Attenswithin 24 hours after deatl To the Funeral Director: or mpletely filled in by the	Certification:	3 Suicide 6 Could not be determined	9 200 Dinon of Injur	ry - At home, farm, s (Specify)	treet, factory, office		28f. Location (S City or Tow		umber or Run	al Route Number,	
	he Hospit n 24 hours he Funera sletely fille	edical C	29a. Certifier 11 Certifying Ph (Check only one) 1 Medical Exam	nysician: To the best of niner: On the basis of e and manner state	examination and/or ii	ith occurred at the tim	ne, date and place pinion, death occu	, and due to the or rred at the time, o	ause(s) and date and pla	d manner as s ce, and due to	stated. o the cause(s)	
	To the Comp	Ž	29b. Signature and title of certifier	loy M.D		29c. License	number			gned (Month,		
	Ì		30. Name and address of person who				7695	/	<i>laich</i>	29,	LOOK	
	N		30. Name and address of person who	completed cause of 08	an (nem 20a) (19pe	, i thuy		volum — n	III (X Y L.)	2007 P		
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 2 2004	32. Registrar	's Signature	rake	- m 1 0000 1 000 1	1 to to 1 1 1 1 1 1 1	A T T T WOOD I	F F Man Same	J. 15216 2	

			1 - For State Registrar	State of	Maryland / De	partmen <i>ertificat</i>	t of H e of i	lealth a Death	and M		giene Reg. No. 2 (004	10166
	Physic		1. Decedent's Name (First, Middle, Gloria Jean	A 1			_			2. Date of Dea		04 Year	3. Time of Death 5:30 P M
	/Medi Exami	ner	4a. Facility Name (If not institution, 19071 Glen E11 5. Social Security Number	en Avenue	er) Age (In yrs. last birthd	Va.		r Location o		8. Date of Birt	4c. Coun	ty of Death Mary	's
	Funeral Director		578-34-8815 Usual Residence of Decedent	1□ M 2□ TF	75 Yrs	Months	Days	Hours	Min.	Month Day March	25,192	9 Wasi	place (State or Foreign ntry) nington, D(
	deeth with the Maryland me 23a or 28a-f show rittust be instiffed at	ctor	Maryland St. M	ary's	10c. City, Town o								1 ☐ Yes 2 No
	eth with the 23a or 2 ust be no	Funeral Director	10e. Street and Number 19071 Glen E11	en Avenue		10f. Zip	Code	2069	92		10g. Citizen o		ntry?
980	ours efter de ral', or itame Examinar m	ğ	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Deceded Armed Force 1 □ Yes 2 If Yes, Give Year or Date	₽No	3. Was Deced If Yes, spec		ispanic Orig in, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	14. Ra Bl	ice - Americ ack, White, ify: V	
21215-0036	permit. Peges 1 and 2 should be filed within 72 hours efter des Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other then "natural; or iteme any injury or other traumatic event, the Madical Examiner in once.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4	or 5+)	cedent's Usua ive kind of wor e. DO NDT us ASUTET	al Occupa rk done d se retired	ation during most i)	of working	ng	16b. Kind of I		
Baitimore, Maryland 2	ould be filed I Mentel Hyg tarked othe	To Be C	17. Father's Name (First, Middle, L John E. Moxley					Eve	elyn	(First, Middle,	Maiden Suma sh	me)	
, Mar	end 2 sh eelth end m 27 is m		19a. Informant's Name/Relationshi George Sheriff/hi		190	71 Gler	E11	len Av	enue	Route Number		-	
timore	Peges 1 Iment of H tant: If Itel		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Spe	ecify)	20b. Place of Di	sposition (Namerematory or	ne of ther place 101s	e) crema	o atory	March 730, 200	20c. Location 04 Cha	-City or To Lrlott	e Hall, MD
Bai	permit Depar impor eny in		21. Signature of Funeral Service Li	56	4	30195	Thre	ee Not	ch R		arlotte		., P.A. , MD 20622
	Physician /Medical		23a. Part1. Enter the disease, or c shock, or heart failure. List o tmmediate Cause (Finat disease or condition resulting in death)	_aa.	n line.	enter the mode			cardiac or	respiratory arr	rest,		Approximate Interval Between Onset and Death
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. CO.	as a consequence of):								8/03
8760,	Icete be executed physicien and s the buriel-trensit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of):								
O. Box 6	The lew requires that the death certificate be executed to be been signed by the attanding physician and bege 2 should be deteched for use as the butiel-trensit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown		2 ☐ Fetal death at time of death	3 □Ectopic pre 5 □ Other (spe						ate of delive	ry Day Year
ords, P.	w requires thet been signed t should be deta		Part II. Other significant condition	s contributing to death	n but not resulting in the	underlying ca	iuse give	n in Part I.			bacco use con es 2 □ No	tribute to th	e cause of death? ably 4 Qunknown
Vitai Records,		Completed by								24a. Was a autops perform	ned?	prior to con death?	osy findings available inpletion of cause of 2 No
Z	Physician: this certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 2000	Hospital:	atient 2 ER/Outpat	ient 3 DO	Othe			(Check only on e 5 ⊅Reside		ne (Specific	1
ion of	ding h. After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Ir (Month, I		of 28	lc. injury Work	at	28	3d. Describe ho			/
Division	tal or Atten s efter deet al Director: ed in by the	Certification;	3 Suicide 6 Could no 4 Homicide determin	286. Place of	Injury - At home, farm, etc. (Specify)	street, factory,	office		28	3f. Location (Sti City or Town	reet and Numb , State)	er or Rurai	Route Number,
	To the Hospital or I within 24 hours effer To the Funeral Directorpletely filled in b	edical	one) 2 Medical E	Physician: To the be aminer: On the basis and manner	st of my knowledge, de of examination and/or stated.	ath occurred a investigation,	t the time in my opi	e, date and inion, death	place, ar	nd due to the ca	ause(s) and ma ate and place.	anner as sta and due to	ated. the cause(s)
)	S S S S S S S S S S S S S S S S S S S	Σ	29b. Signature and title of certifier	Hotel	10	290.	License	number	85	29	9d. Date signe	d (Month, L	Day, Year)
	H		30. Name and address of person of			e, Print)			<u> </u>		-/		/
2	Sta Registr		Dr. Horton, L 31. Date filed (Month, Day, Year) APR 0 2 2004		strar's Signature	rould							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 2. Date of Death 1. Decedent's Name (First, Middle, Lest) Month **Physician** Spiege1 Harry 25, 2004 March 1:37 PM · /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner Laure1 Prince George's Laurel Regional Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Months 1 M 2 □ F Yrs. 011-14-5068 92 25, 1912 Massachusetts Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Chevy Chase Maryland Montgomery Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20815 4821 Morgan Dr. United States Funeral permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural". or leasing highly or other traumatic event. 14 Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White à 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Reporter Newspaper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Spiege1 Jennie Drozd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mark Spiegel / Son 4821 Morgan Dr., Chevy Chase, MD 20b. Place of Disposition (Name of March 29 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2004 Beltsville, MD 21. Signature of Funeral Service Rapp Funeral and Cremation Services M00382 933 Gist Ave., Silver Spring, MD 23a. Part1. Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Myocardial Infarction Acute Examiner Respiratory Distress Acute Iclan/Medical Examiner attending physician and I for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Aspiration Pneumonia Division of Vital Records, P.O. Box 68760 Acute The law requires that the death certificate be Due to (or as a consequence of): ed by the a 23b. Did tobecco use contribute to the cause of death? Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. Physic 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown signed b Advanced Dementia þ cate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1□ Yas ₹ No 1 □ Yes 2 □ No certificate After this certification of funeral director, I Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 IN ER/Outpatient 3 IDOA Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Injury 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 6 To the Hoapital within 24 hours & To the Funeral (completely filled the Hoapital 29a. Certifier 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edicai (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier D20367 March 26, 2004 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Jøel Kalman, M.D.; 6111 Executive Blvd.; Rockville, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

APR Q 2, 2004 State

DHMH 16 Rev 6/95

Registrar

	1 - For State Registrar	State of Maryla		artment of H		F	Reg. No. ZUUL	
Physician	Caroline	, Last) Brown	Sc	hauffler		2. Date of Dea Month March	Day Year 27, 2004	3. Time of Death 4:00 AMM
/Medical Examiner	4a. Facility Name (If not institution, 1121 Gold Mine	Rd.		4b. City, Town, or Bro	Location of Death okeville		4c. County of Dea Montgom	ery
Funeral Director	5. Social Security Number 577-38-9574 Usual Residence of Decedent	6. Sex 1 □ M 2 ☒ F 7. Age (In yrs	i. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birtl (Month, Da) Nov. 5,	y, _{Year)} 9. Bir 1914 Wasi	thplace (State or Foreign buntry)
anyland show	10a. State 10b. County	10c. C	ity, Town or Lo	Brooke	vi11e			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
or 28a-	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Re Completed by Funeral Director		12. Was Decedent Ever in Armed Forces?	i	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		erican Indian,
ed within 72 hours. ygiene. her than "natural", it, the Medical Exa.			(Give	dent's Usual Occupi kind of work done o DO NOT use retired eacher	ation during most of wor l)	king	16b. Kind of Business Public Sc	
Mental Hyg arkad othe atic event,	17. Father's Name (First, Middle, I	lson Brown			18. Mother's Nam Carol		Maiden Sumame) ator Ta	ylor
d 2 shou th and M 7 is man traumat	19a. Informant's Name/Relationsh William B. Sch			ng Address (Street a			or, City or Town, State,	Zip Code) 833
Pages 1 and ent of Heall nt: If item 2 ry or other	20a. Method of Disposition 1 Burial 2 © Cremation 4 Donation 5 Other (S)	20b. 3 □Removal from State	Place of Dispo	esition (Name of matory or other place	(e) Marc	h 30	20c. Location - City or Beltsvi	Town, State
permit. Pages Department of Important: If it any injury or o	21. Signature of Funeral Service	gicensee Moo3	82 R	2. Name and Address app Funer 33 Gist A	ss of Facility al and C	remation	Services	910
Cate be executed Cate be executed Wedical Examiner The burial-transit	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unease or injuly) that initiated events resulting in death) Last	complications that caused the decony one cause on each line. Emph 1 a. Due to (or as a consection of the consection o	oquence of):	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate interval Between Onset and Death
death certifice e attending of for use as		23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
es the	Patri, Other significant condition	ons contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	111	obacco use contribute t	o the cause of death?
The lay ate has page 2						24a. Was autop perfor 1 \(\text{Yes} \)	prior to death?	utopsy findings available completion of cause of
Physicien: this certifical director.	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	er: 4 🗆 Nursing H		ne) dence 6 ①Other (Spe now injury occurred	ocify)
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attending filled in by the funerel Director.	27. Manner of Death 1 Natural 2 Accident investic 3 Suicide 6 Could determ	not be ined 28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	reet, factory, office		28f. Location (S City or Ton	Street and Number or R vn. State)	ural Route Number,
To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	29a. Certifier 1 Certifyin	g Physician: To the best of my ki Examiner: On the basis of examinand manner stated.						
To the within To the comp	29b. Signature and title of certifier	mile 100		29c. Licens	e number		29d. Date signed (Mon	
13	FRANK J. MA	• '	FREDER	Print) ICK RD	#213 6	NETHER	250026, mu	26877
State Registra	* D D D D D D D D D D D D D D D D D D D	32. Registrar's Sig	nature	pach				

			1 - For State Registrar	State of Maryla	nd / Depa	artment of F	lealth and <i>Death</i>		ene200L	10169
			Decedent's Name (First, Middle, Last	1)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Emily Louise Turek					March	31, 200	04 8:50 Å
	Examin	er	4a. Fecility Name (If not institution, give			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	r Location of Dea	th	4c. County of Dee	eth .
	Funeral		Joseph Ritchey 5. Social Security Number 6. Se		. last birthday)	If Under 1 Year	imore If Under 24 Hrs		n/a	rthplace (State or Foreign
	Director			7 57	2 Yrs.	Months Days	Hours Min		rear)	Maryland
pue	3		Usuel Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ecation				10d. Inside City Limits
d 21215-0036 filed within 72 hours after death with the Maryland	-f sho	Į.	Maryland Baltim		•	nsville				1 ☐ Yes 2 No
h the	r 28a	Funeral Director	10e. Street and Number	.020	caco	10f. Zip Code		100	g. Citizen of What C	ountry?
ith wit	23a o uat be	a D	715 Maiden Choi	ce Lane HR	404	21228			United S	tates
er dea	items	nuei	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
)36 Irs aft	f, or	by F	1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	1 □ Yes 2√2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: Wh	iite
5-0 2-2-1	nature ical E	ted	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occup	ation	diag 16	3b. Kind of Business	
Maryland 21215-0036	hen .	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	ixing		
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and p	ked o	То Ве	Arthur Jerome Sto	lte				Catheri	,	ene
aryla	and M s mar umat		19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Street		ural Route Number, C		
, M	Department of Health and Mental Hygiene. Importent: or items 23a or 28a-f show importent: If item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other treumetic event, the Medical Examiner must be notified at once.		Authur M. Stolt	e, Jr				Gwynn Oak	, Marylar	nd 21207
more Pages 1	or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		Place of Dispo cemetery, crer	sition (Name of matory or other place	ce)	Date 20	c. Location - City or	Town, State
Baltimore, permit. Pages 1 ar	intmen intent: njury		* 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens		udon 1	Park May ! Name and Addre				, Maryland
Ba F	Depa impo eny ir		Man U	Zink			пс	ubbard Fund Me, Baltim		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	ica ions that caused the dea						Approximate Interval Between
Ph	ysician		Immediate Cause (Final disease or condition	<u>^</u>	640000	ncer				Onset and Death
	Medical caminer		resulting in death)	Due to (or as a conse	quence of):					2
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O,	ohysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a consec	quence of):					
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ox 6	attending ph	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregn	ancv				22d Date of de	livani
Beat the second	d for u	Iclar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	aldeath 3□]Ectopic pregnancy] Other <i>(specify)</i>			23d. Date of de Month	Day Year
at the	ed by the a	hys	9 🗆 Unknown	9□ Unknown						
S, in the state of	sbeen signed to should be deten	by	Part II. Other significant conditions co		sulting in the u	nderlying cause give	en in Part I.			the cause of death?
orc.	plnods	eted	LIVEC ME	tagtoses						robably 4 bnknown
Records,	20 00	Completed						24a. Was an autopsy performe	d2 prior to death?	utopsy findings available completion of cause of
	is certificate hi	a	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes 2 ☐	No 1 □ Yes	; 2□ No
	this cer al direc	To B	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Othe	ar	lome 5 Residence	ce 6 MOther Spe	city hospice
O C	h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe how		
Division of For Attending Phy	after death Director: / in by the f	ertification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm sto		Yes 2 □No	28f. Location (Stree	at and Number or B	ural Route Number
Div	s after	Sertif	4 Homicide determined	building, etc. (Speci	(fy)	out, ractory, office		City or Town, S	State)	arai rioute riuniber,
Div To the Hospital or	within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier Certifying Phy	sician: To the best of my known or the basis of examination	owledge, death	occurred at the tim	ne, date and place	, and due to the caus	se(s) and manner as	s stated.
the	within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner stated.		29c. License				
7	≥ 1 S		200. Signature and title or continuor	20/100	_ 1				Date signed (Mont	- ·
	4		· 7 - 1 - 1		7.		3006		1 1 4/ / 6	D//
	16		30. Name and address of person who co	ompleted cause of death (Iter	m 23a) (Type.	Print)				-4
	16		30. Name and address of person who co	ompleted cause of death (Item 20 00 00 00 00 00 00 00 00 00 00 00 00 0	m 23a) (Type,	Print) N. Rea Span	d St.	Balto	Mg :	21201

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 **Physician** FEB. 26, 2:35 PM THOMPSON, Jr LAWRENCE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES Laurel 616 9th Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months, Dev. Year) | Jan. 12, 1934 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 11XM 2□ F Maryland 70 220-28-6217 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural; or items 23s or 28s-f show 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or itams 23s or 28s-f show other traumatic event, the Medical Exams we must be notified at ty Yes 2 □ No Laurel Director Pr. Geo. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U.S.A. 20707 616 9th Street Funerai 12. Was Decedent Ever in U.S. Armed Forces? US Yes 2 □ No If Yes, Give Year or Dates: 56 — 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ZNo Specify: þ 3 Widowed 4 Divorced 56-58 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Citizens Nat'l Elementary/Secondary (0-12) College (1-4or 5+) Laborer Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alice Clark Lawrence A. Thompson, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tran QDCS. 226 Sweet Pine Dr., Laurel, MD 20724 Nancy Daniels (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vet.Cem. 3/4/2004 Crownsville, MD □Donation 5 □ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, PA 21/ Signature of Funeral Service Licensed 246 N Washington St Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one plause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY ARTERY DISEASE YEARS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Carcinoma of Prostate Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Carcinoma of Pharynx page 2 : autopsy performed 1 ☐ Yes 2 X No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 ☐ Yes 20 No Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attending 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation death 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated the 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number M D2318 March 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel, MD 20707 R.G. Bhujraj 704 Gorman Ave 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

Registrar

DHMH 17 Rev 1/2001

APR 0 2 2004

TAYLOR, VALENCIA 3.27.04 6:43 PM, Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760.

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Physicia	ın	Decedent's Nama (, Last)		_,			ml-				2. Date of D Month	eath 27 ^{Day}	y 2004		3. Time of Death 6:43p M
/Medic	al	Valence 4a. Facility Name (If n		aive stre	eet and nu	She	rı		Taylo		Location of	of Death			. County of De		0.43p
Examin	er	Gilchris								owso					Balti		re .
Funeral		5. Social Security Nur	mber	6. Sex	1 2 ∑ F	7. Age	` '	ast birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of B	ay, Year)		ountry,	e (State or Foreign
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be file tal Hy d oth	Be (17. Father's Name (F		Last)							-		(First, Middle	e, Maiden			
12 should be filed within hand Mental Hygiene. 7 is marked other then "traumatic event, the Meter	2	Gardner		nin (Tvna	Print)		Ta	ylor	no Address	/Street a		herr		her City o	Sto. or Town, State,		ode)
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item item othe	1	20a. Method of Dispo	osition			- C1-1-	20b. Pl	ace of Dispo	sition (Nan	ne of	1		Date		ocation - City o		State
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permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evoluce.		21. Signature of Fund	eral Service	Licensee ~	111			22	2. Name an						re, Md.		1202
		23a. Part1. Enter the shock, or heart	e disease, or	c plica	tions that	caused	thereath	o not ent	March er the mod				or respiratory		North A	A	pproximate
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ficate be e physiciar s the burit	lical			d													
leath certifica attending ph	Physician/Medical	IF FEMALE:		230	c. If ves. or	utcome	of pregnar	ncv							23d. Date of de	alivon	-2 III - 33
death death death death	ician	23b. Was decedent print the past 12 print 1 and 12 print	nonths?		1☐Live 4☐Preg	birth gnant at	2 Fetal time of de	death 3	Ectopic pr Other (sp						Month	Da	ay Year
that the de ned by the a	hys	9 ☐ Unknown V	,		9□ Unk												
w requires that sheen signed to should be det	þ	Part II. Dthar signific	cant condition	ons contr	ibuting to	death bi	ut not resu	ulting in the u	nderlying c	ause give	n in Part I				1	to the o	cause of death?
requi	eted												24a. Wa	/	7(-		findings available
he lav e has age 2	Completed												auto	opsy formed?	prior to death?	comp	letion of cause of
ysician: The l is certificate ha director, page	ø.	25. Was case referre	ed to medical								26. Place	of Death	1 ☐ Yes n (Check only	one)	1 □ Ye		
Physici this ce al direc	To B	examiner?		Ho		Inpatie		ER/Outpatier			4 🗆 NU		me 5 Res		Other (Sp	ecity	rospice
ding Phi th. After thi funeral	ion:	27. Manner of Death Natural	5 Pendin		28a. Date (Mo	e of Injui onth, Day	ry y Year)	28b. Time o Injury	f A	28c. Injury Work	rat ⟨? Yes 2 □		28d. Describe	how inju	ry occurred		
Attenor death octor:	ifical	2 Accident 3 Suicide	6 Could	not be	28e. Plac	ce of Inju	ury - At ho	me, farm, st							nd Number or I	Rural A	oute Number,
s after al Dire	Certification;	4 Homicide	,		Dulli	aing, etc	c. (Specify	<i>'</i>					City of Te	own, State	B)		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. The confidures that the death certificate be to the Lenaral Director. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	edical				ar: On the		f examinat) and manner a d place, and du		
o the	Med	10	title of certifie	1 1	and ma	1111101 512	1180.		290	c. License	number			29d. Da	ite signed (Mor	nth, Da	y, Year)
F 5 F 0		MAK	La	U	1-11	D			I.	15	23	0	>	Mar	ch 27	2	∞ 4
5		30. Name and addre	ss of parson		pleted car	use of d	\ \	23a) (Type,	Print)	hen	les	ST	Balt	14.04.8	ch 27 De M) 3	21200
Sta	te	31. Date filed (Month	h, Day, Year)		32.	Registra	ar's Signat		1	- GA .	-	1 -	170011	VUOI	LE VVE		727
Registr				Al	K U	20	U4	turg! Allaces	الک ر	P	DB4CL	.50					

hysici		Registrar 1. Decedent's Name (First, Middle, L	ast)	Ce	Timeate of	Death	Reg.	No.2U04	3. Time of Death
/Medic		LANIA	D.	U	LLMAN		MARCH 26,	2004 Year	11:15 A
Examir		4a. Facility Name (If not institution, g.				or Location of Deati		4c. County of Deal	h
		ROLAND PARK PLAC 5. Social Security Number 6.		e (In yrs. last birthday	BALTIMO If Under 1 Year)RE If Under 24 Hrs.	8. Date of Birth	N/A	holace (State or Fore
ineral rector		113-10-0857 Usual Residence of Decedent	1□ M 2 √2 F	73 Yrs.	Months Days	Hours Min.	03713719	31	hplace (State or Fore buntry) NC
whow a		10a. State 10b. County		10c. City, Town or L					10d. Inside City Limi
or Items 23s or 28s-f show reinst must be notified at	Director	MD. N	/A	BALTIMOR	L 10f. Zip Code		100	Citizen of What Co	1 Yes 2 1
3a or	ai Dir	830 W. 40th STRE	ET		212	211		U.S.A.	ond y :
SE TA	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of H	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
l', or h	by Fu	1 Never Married 2 Married 3 Married 4 Divorced	1 ☐ Yes 2 💢 f If Yes, Give Year or Dates:	40	1□Yes 🛣 No			Sassifu	ITE
natural', o edical Exa		15. Decedent's l	Education	16a. Dece	edent's Usual Occup kind of work done	pation	tring 16t	o. Kind of Business/	
rthan "r tha Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5	ife.	DO NOT use retire	d)		SENTED AL	up.
event, In		17. Father's Name (First, Middle, Las	1	KEUE	PTIONIST	18. Mother's Nan	ne (First, Middle, Mai	CENTER CLI)R
g 6	To Be	UNKNOWN	1	UNKNOWN		UNKNO	WN	UNKNOWN	
item 27 is marke other treumatic		19a. Informant's Name/Relationship		1			ral Route Number, C		
em 27 ther tr		FEDDER & GARTEN 20a. Method of Disposition	/ ATTORNEY	S 36 S	osition (Name of	S STREET		LTIMORE, Location - City or	
= 5		1 Neurist 2 Cremation 3 4 Donation 5 ØOther (Special Control of the Control of t		DRUID RID	ematory or other pla				
윤글		21. Signal of Emeral Sovice Lice	11 4/1				L LEVINSON	PIKESVILLI I & BROS	
any ir	1.1	Y/M/MMS	Trug	a 8	900 REIS1	ΓERSTOWN	ROAD - PIK	ESVILLE,	
學		25a. Party. Enter the disease, or co shock, or heart failure. List off	y one can son each lin	the death. Do not en	nter the mode of dyir	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
ician		Immediate Cause (Final disease or condition resulting in death)	.a. A	cute Re	spirato	cy Dis	tress		one hour
dical niner		1	Due to (or as	a consequence of):		1			La
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):					ten year
-trans	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	0.0000000000000000000000000000000000000					
physician and the burial-transit	ical E		Due 10 (01 45	a consequence of):					
g phys as the	P		d						
attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1☐Live birth		□Ectopic pregnance	y		23d. Date of deli	
= 0	ysici	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at 9☐ Unknown		Other (specify)			Month	Day Year
the a	두		contributing to death h					es une sentebute te	
ached		Part II. Other significant conditions	continuously to death b	ut not resulting in the t	underlying cause giv	ven in Part I.	23e. Did tobac	co use contribute to	the cause of death?
gned by the se detached	by	Part II. Other significant conditions		ut not resulting in the t	underlying cause giv	ven in Part I.	23e. Did tobac		
s been signed by the	by	Part II. Other significant conditions	contributing to death b	ut not resulting in the i	underlying cause giv	ven in Part I.	1 ☐ Yes 24a. Was an	2 No 3 Pr	obably 4 Unknow
sale has been signed by the page 2 should be detached	by	Part II. Other significant conditions	contributing to dealing	ut not resulting in the	underlying cause giv	ven in Part I.	1 🗆 Yes	2 No 3 Pro	topsy findings availab
sale has been signed by the page 2 should be detached	Be Completed by	25. Was case referred to medical examiner?	Hospital		0**	26. Place of Dea	1 Yes 24a. Was an autopsy performed 1 Yes 2 th (Check only one)	2 No 3 Production 12 Ab. Were au prior to death?	obably 4 Unknown topsy findings availate completion of cause of 2 No
this certificate has been signed by the al director, page 2 should be detached	To Be Completed by	25. Was case referred to medical	Hospital: 1 ☐ Inpatie	ont 2□ER/Outpatie	int 3□ DOA Oth	26. Place of Deaner: 4 Aursing H	1 Yes 24a. Was an autopsy performed 1 Yes 2	2 No 3 From 24b. Were au prior to death? No 1 Yes	obably 4 Unknown topsy findings available completion of cause of 2 No
in Arei tils cermicate nes been signed by the ne funeral director, page 2 should be detached	To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	ont 2□ER/Outpatie	ont 3 DOA Oth	26. Place of Deaner: 4 Aursing H	1 Yes 24a. Was an autopsy performed 1 Yes 2 th (Check only one) ome 5 Residence	2 No 3 From 24b. Were au prior to death? No 1 Yes	obably 4 Unknown topsy findings availate completion of cause of 2 No
rt: Atler tris certificate has been signed by the he funeral director, page 2 should be detached	To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da)	ont 2 ER/Outpatie ry y Year) 28b. Time o Injury	ont 3 DOA Oth	26. Place of Dea ner: 4 Aursing H ry at	1 Yes 24a. Was an autopsy performed 1 Yes 2 th (Check only one) ome 5 Residence	2 No 3 Production of the stand Number of Rule	obably 4 Unknow topsy findings availab completion of cause of 2 No
nr: Aller this certificate has been signed by the he funeral director, page 2 should be detached	Certification: To Be Completed by	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da) be d 28e. Place of Inju building, etc.	ont 2 ER/Outpatie ry Year) 28b. Time of Injury ury - At home, farm, st	ont 3 DOA Othor of 28c. Injur Wor M 1	26. Place of Dea 1er: 4 A ursing H ry at rk? Yes 2 □ No	1 ☐ Yes 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ th (Check only one) ome 5 ☐ Residence 28d. Describe how i 28f. Location (Stree City or Town, S	2 No 3 Production of the state	obably 4 Unknown topsy findings available tompletion of cause of 2 No Strify)
ne funeral director, page 2 should be detached	cal Certification: To Be Completed by	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da)	ont 2 ER/Outpatie ry y Year) 28b. Time o Injury ury - At home, farm, st c. (Specify) of my knowledge, deat	ont 3 DOA Other Section of Section 1 DOA Months of Sec	26. Place of Dea ner: 4 → lursing H ry at rk? Yes 2 □ No	24a. Was an autopsy performed: 1 Yes 2 th (Check only one) ome 5 Residence 28d. Describe how in 28f. Location (Stree City or Town, S	2 No 3 Production of the state	topsy findings available completion of cause of 2 No No No Northly)
er: Aller this certificale has been signed by the he funeral director, page 2 should be detached	Certification: To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not determine 29a. Certifier Cneck only and 2 Medical Example.	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da) 28e. Place of Inju building, etc Physician: To the best	ent 2 ER/Outpatie ry y Year) 28b. Time of Injury ury - At home, farm, st c. (Specify) of my knowledge, deat examination and/or in ated.	ont 3 DOA Other Section of Section 1 DOA Month 1 Doals of Section 1 DOA Month	26. Place of Deaner: 4 Hursing H ry at rk? Yes 2 No me, date and place ppinion, death occurse number	24a. Was an autopsy performed. 1 Yes 2 Sth. (Check only one) 28d. Describe how in the control of the control of the causered at the time, date	2 No 3 Production of the control of	topsy findings available bompletion of cause of 2 No
After this certificate has been signed by the funeral director, page 2 should be detached	edical Certification: To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not determine 29a. Certifier Cneck only and 2 Medical Example.	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da) 28e. Place of Inju building, etc. Physician: To the best	ent 2 ER/Outpatie ry y Year) 28b. Time of Injury ury - At home, farm, st c. (Specify) of my knowledge, deat examination and/or in ated.	ont 3 DOA Other Section of Section 1 DOA Month 1 Doals of Section 1 DOA Month	26. Place of Deaner: 4 Hursing H ry at rk? Yes 2 No	24a. Was an autopsy performed. 1 Yes 2 Sth. (Check only one) 28d. Describe how in the control of the control of the causered at the time, date	2 No 3 Production of the control of	topsy findings availatempletion of cause of 2 No

State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 950 **Physician** VRAD MARC /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Neme (If not institution, give street and number) Examiner Ħ PARKVILLE TIMORE WALTHER BLVD If Under 1 Year If Under 24 Hrs. 8. Date of Birth

No. 1 Hours Min. A (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 10 M 2 F 220.20.784 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County rel', or iteme 23s or 28e-f show Examiner must be notified at 1 ☐ Yes 2 No MARYLAND BALTIMORE ARKVILLE Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 BLVD WALTHER Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) t and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No "naturel", or Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced permit. Pages t and 2 should be filed within 72 hx Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Mudical ango. Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **EDGEWOOD** MECHANICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WAGNER MENDI ONRAD 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 NOC 2108 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Pemoval from State DULANEY ALL APRIL 2, 2004 * 4 ☐ Donation 5 ☐ Other (Specify) GARDAUS 22. Name and Address of Facility EVANS FUNDRAL 21. Signature of Funeral Service L PARKVILLE, MD 21234 BYCO HAKTORD RD. 1101 23a. Pert1. Enter the disease, or complication shock, or heart failure. List only the cr Approximate Interval Between Onset and Death d the dea Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** oequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown detached 9 III Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be Du 1 ☐ Yes 2 No 3 Probably 4 Unknown Monce 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2□ No 1 Yes 1 Yes 2 ☑ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) the funeral 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: After t Hospitel or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 3 31 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kurlle and 21234 8800 Wal They BIVD my) LUMENTHA Bruc 2 36 Registrar's Signature 31. Date filed Appin, gay year 104 State

DHMH 17 Rev 1/2001

Registrar

Pleas

7. Age (In yrs. last birthday)

12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:

College (1-4or 5+)

Due to (or as a consequence of

Due to (of as a consequence of).

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

1 🗌 Inpatient

28a. Date of Injury (Month, Day Year)

9□ Unknown

Hospital:

4☐Pregnant at time of death

Yrs.

10c. City, Town or Location

se Type or Print in Black Indelible Ink. Ensure A	Il Copies Are Legible.	
State of Maryland / Department of Health and M	Mental Hygiene 2004	10171
Certificate of Death	Reg. No.	, 0 , 1
Last)	2. Date of Death	3. Time of Death
11/atkins	MARCH 29, 2004	6:07P. M

4b. City, Town, or Location of Death

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

Min.

BALTIMORE If Under 1 Year | If Under 24 Hrs.

Days

2**/2** No

19b. Mailing Address (Street and Number of

22. Name and Address of Facility

a Hypertensive Arteriosclerotic Cardiovascular Disease

eath. Do not enter the mode of dying, such as cardiac or respiratory arrest,

2403 Edgewood

EVANS FUNE

3 □Ectopic pregnancy

3□ DOA

28c. Injury at Work?

5 Other (specify)

20b. Place of Disposition (Name of cometery, crematory or other)

John's Cencton

(Give kind of work done during most of working life. DO NOT use retired)

Manage

PARKVILLE

1 Tyes

16a, Decedent's Usual Occupation

Physician /Medical Examiner

4a. Fecility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL

For State Registra

1. Decedent's Name (First, Middle.

20-507

1 Never Married 2 Married

12 17. Father's Name (First, Middle, Last)

Dh 19a. Informant's Name/Relationship (Type, Print)

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

21. Signature of Funeral Service Lig

23a. Part 1. Enter the disease shock, or heart failure.

Immediate Cause (Final disease or condition

Sequentially list conditions, r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1√2 Yes 2 □ No

27. Magner of Death

1 Natural

3 🗌 Suicide

29a. Cartilia

4 Homicide

9 Unknown

resulting in death)

IF FEMALE:

10b. County

6. Sex

DALTIMORE

15. Decedent's Education (Specify only highest grade completed)

1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)

5. Social Security Number

10e. Street and Number

10a. State

MD

Funeral Director

the Maryland or 28a-f show traumatic event, the Medical Examiner must be notified at Director Items 23a Completed by Funeral death Pages 1 and 2 should be filed within 72 hours after ŏ natural', rthan permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other ther any injury or other traumatic event, Irean

To Be

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Examiner

Completed by Physician/Medical

Be

10

Medical Certification:

or Attending Physician: The law requires that the death certificate be executed burial-transit and Division of Vital Records, P.O. Box 68760 the attending physicien as the signed by been in by the funeral . After death

within 24 hours after deatl To the Funeral Director: To the Hospital completely filled

29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARONICA-POLLAK MD. PATRICIA 31. Date filed (Month, Day, Year) State

₹XER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1... Certifying Physician. To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) MARCH 30,2004

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4c. County of Deeth

10g. Citizen of What Country?

16b. Kind of Business/Industry

14. Race - American Indian, Black, White, etc.

Specify: white

PARKVILLE, MD

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

3 Probably

1 ☐ Yes 2 ☐ No

2 No

28d. Describe how injury occurred

24a. Was an autopsy performed

1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

Day

24b. Were autopsy findings available prior to completion of cause of death?

2□ No

Approximate Interval Between Onset and Death

Year

4 Unknown

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 XNo

8. Date of Birth (Month, Day, Year)

ther's Name (First, Middle, Maiden Sumame,

Rural Route Number, City or Town, State, Zip Code) Har Kville

TIMORE, MD 21234

CHAPEL, 8800 HARFORD RD

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

Registrar ADD 19 2004

DHMH 17 Rev 1/200

ORIGINAL

O.C.M.E.

29c. License number

1 ☐ Yes 2 ☐ No

	39		For State Registrar	State of Maryla	nd / Dep	artment of rtificate of	Health a	and Mental Hy	giene Reg. No.2004	10175
	Physici		Decedent's Name (First, Middle, Last) Margaret Mary Ward		_			2. Date of Da. Month		3. Time of Death 9:15 p M
	/Medio Examir		4a. Facility Name (If not institution, give s	reet and number)		4b. City, Town,			4c. County of Dea	
			The Woodlands	2 4 4	- franktat (Middle If Under 1 Yea		24 Hrs. 0. D	Balti	
	Funeral Director		5. Social Security Number 6. Sex 1 1	M 212kF 7. Age (In yr.	s. last birthday) Yrs.	Months Days	If Under	Min. 8. Date of Bird (Month, Date of Bird) Feb. 15	y, Year) Co	tholace (State or Foreign ountry) Tyland
	ס		Usuat Residence of Decedent					rep. 13	, 1905 Mai	
	show).	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	the M	ecto	Maryland Baltimore 10e. Street and Number	M1	ddle Ri	10f. Zip Code			10g. Citizen of What Co	
	3a or	i D	4040 Chestnut Road			21220			U.S.A.	
	ems 2	Funeral Directo	11. Maritat Status 1	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of	Hispanic Ori	gin? (Specify Yes or No , Puerto Rican, etc.)		
36	s atte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify:	
Maryland 21215-0036	be filed within 72 hours atter death with the Maryland ntal Hyglene. ad other than "natural", or Items 23a or 28a-f show event, the Modical Exertings must be rotified at	ed b	15. Decedent's Educ		16a. Dece	dent's Usual Occi	pation		16b. Kind of Business	Thite Industry
215	within 72 ene. than ni	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retir	e during most ed)	t of working		,
2	e filed within al Hygiene. I other than vent, Ine Mo	Con	8		Seams	stress	10.00.0			lanufacturer
and	ntal H ed otl	Be	17. Father's Name (First, Middle, Last) Francis Mueller					er's Name (First, Middle,		
Z	should be ind Mental s marked o	2	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Stree		aret Fische: or or Rural Route Numbe		Zip Code)
Ma	and 2 alth a 127 is or trau		Alvin F. Ward (Son)				d, Baltimore		
ore	of He of He Mitem		20a. Method of Disposition 1XDBurial 2 □ Cremation 3 □ Re		Place of Dispo cemetery, cre-	osition (Name of matory or other pla	ace)	Date	20c. Location - City or	Town, State
Baltimore,	tment tant: tant:		* 4 □Donation 5 □ Other (Specify)	Ho					04 Baltimor	e, Maryland
Bal	permit. Pages 1 and 2 should b Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic e anges.		21. Signature of Funeral Service License		1	2. Name and Addr F	Bruzdz	inski Funer rn Avenue,	al Hoe, P.A	
O	45		23a. Part1. Epter the disease, or complice shock or heart failure. List only one	ations that caused the de	ath. Do not en	ter the mode of dy	ing, such as	cardiac or respiratory ar	rest,	Approximate the total Between
¥	Physician	:	Immediate Cause (Final disease or condition	and the same of th	omic	Can	dian	yop ally	,	Onset and Death
*	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):			0 0		
l,		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):					
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ö,	e exec		resulting in death) Last	Due to (or as a conse	equence of):			· · · · · · · · · · · · · · · · · · ·		
38760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	dicai	d.							
Box 6	death certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of preg					23d. Date of del	ivery
Ö.	death ne atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐Fe 4☐Pregnant at time of 9☐Unknown		Ectopic pregnant Other (specify)	су		Month	Day Year
P.O.	res that the de igned by the a be detached f	Phys	9 Unknown					non Dida	bacco use contribute to	the serve of death?
ds,	signe d be d	by	Part II. Other significant conditions cont	5 4 4	Mun	Advs.				obably 4 Unknown
COL	w requir been si should I	iete	CARD	- Congle				24a. Was		itopsy findings available
Division of Vital Records,	The lav	Completed	COTT.					— autop	sy prior to death?	completion of cause of
/ital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?			7 - 17		of Death (Check only or		20110
of	Physi this c	P	1 Tyes 2 No	spital: 1 Inpatient 2	ER/Outpatier	IL SULDON		rsing Home 5 Resid		
OU	ling After	tion	1 Naturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	W	myat ork?]Yes 2.⊟1		ow injury occurred	LIVING.
Visi	Attending at death. ector: After by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of tnjury - At building, etc. (Spec	home, farm, str	reet, factory, office		28f. Location (S City or Tow	Street and Number or Ru	ıral Route Number,
Ö	ital or irs afte ral Dir iled in									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examination)	cian: To the best of my ki er: On the basis of examinand manner stated.	nowledge, deatl nation and/or in	h occurred at the t vestigation, in my	ime, date and opinion, deat	d place, and due to the o h occurred at the time, o	ause(s) and manner as date and place, and due	stated. to the cause(s)
	ro the vithin ro the	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Monti	
)	7) Also MD			D-34			04-02	
	10		30. Name and address of person who con MALIKA WASRE	npleted cause of death (Ite 3M · 70	em 23a) (Type,	Print) 4STER	N G	BLUD -	MD-2	1221.
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	pature					

			State of Maryland / Department of Health and M 1- For Registrer Certificate of Death		giene 0 (04 10176
	Di		Decedent's Name (First, Middle, Last)	2. Date of Dea		3. Time of Death
	Physici /Media		Dorothy Grace Woods	March	24 2	004 9:35 AM
	Examir	ıer	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	6	4c. County	of Death
			5. Social Security Number 6. Sex 7. Asadin yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Data of Bird	2 / 100	D. Bishbalasa (Chara as Familia
	Funeral Director		216-26-7904 1 M 2X0 F 81 Yrs. Months Days Hours Min.	8. Date of Birt (Month, Day 04/02/	y, Year) 1922	9. Birthplace (State or Foreign Country) Connecticut
	70		Usual Residence of Decedent	, , , , , ,		
	anylar show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1X Yes 2 □ No
	Ne Mi	ecto	MD Harford Havre de Grace 10e. Street and Number 10f. Zin Code		10 000 44	
	with t	급			10g. Citizen of W	nat Country?
	death	Funeral Director	11. Merital Status 21078 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No-		- American Indian,
	after o	Ē	Armed Forces? 1 Never Married 2 Married 1 Yes, Sive 1 Yes, specify Cuban, Mexican, Puerto 1 Yes, Give 1 Yes, 2 No Specify:	Rican, etc.)		k, White, etc.
	5-UU36 72 hours after death with the Maryland natural', or itams 23a or 28a-1 show disal Evaninet must be notitied at	d by	3A widowed 4 □ Divorced Year or Dates:		Specify:	White
ì	157 r	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of works if the DO NOT use retired)	ing	16b. Kind of Bu	siness/Industry
,	with!	E C	Elementary/Secondary (0-12) 10th College (1-4or 5+) Cafeteria Worker		High S	chool
	other ent.	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle,		
	/lar uld by Venta Venta rrked	To B	Frederick Wiemert Florence	e Gibson	n	
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23s or 28s-1 show any rightry or other traumatic avent, the Medical Examinat must be notified at ance.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			
	9, 7 l and lealth im 27 har tr		Robert F. Woods- Son 112 Weber St., Havre	de Grac		
	Saltimore, sernit. Pages 1 a Department of Hee mportant: If item any injury or otha		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place)			City or Town, State
:	ITIN sit. Pa artme ortant injury		.4 □ Donation 5 □ Other (Specify) R.A. Ferris & Co. 103/25 21. Signature of Funeral Service Licensee .22. Name and Address of Facility			ester, PA
(Depril perm perm perm perm perm perm perm perm		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witchell-Smith Fune 123. S. Washington,	ral Hom Havre	ie, P.A.	e, MD 21078
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			3.0043
	LAdimilei	er	Sequentially list conditions, if any, leading to immediate b. Clue to (or as a consequence of):			
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
	/6U, te be execut ysiclan and e burial-trar	Examine	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
(6)	8 / 6U, ate be executed hysician and the burial-transit	cal	d			
	BOX 68 death certificat attending phy d for use as th	Med	IF FEMALE:			
\searrow	BOX lath cert attendin for use	ian/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date Mon	of delivery th Day Year
7	he de the a	Physician/Med	1 Yes 2 No 9 Unknown 5 Other (specify) 9 Unknown			,
6	dS, F.C. ires that the de signed by the d be detached	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
₹ -	rdS quires n sign	ed by	Pneumonia	1□Y	′es 2□No :	3 Probably 4 Unknown
0	HeCOTGS The law requires te has been sign age 2 should be	piete	Dysphaeia	24a. Was a		ere autopsy findings available
A	VI(al Records, P.O. BOX be inclear: The law requires that the death certifical certificate has been signed by the attending phrector, page 2 should be detached for use as it	Completed	R Keymatord arthrop	autop: perfor 1 Tyes	rmed? de	lor to completion of cause of eath? □Yes 2□ No
10)	Ital	Be C	25. Was case referred to medical 26. Place of Death	(Check only or	ne)	
7	OT VITA Physician: r this certificeral director,	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Hor			
00	ding F	tion:	Natural 5 ☐ Pending (Month, Day Year) Injury Work?	28a. Describe n	low injury occurre	a
9	JIVISION I or Attanding after death. Diractor: Afte	fica	3 Suicide 6 Could not be determined determined	28f. Location (S	Street and Numbe	r or Rural Route Number,
~ i	al or A safter of Dirac	Certification;	4 Homicide building, etc. (Specify)	City or Tow	n, State)	
+	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funaral Director: After this certificate ha completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the c ed at the time, d	ause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	To tha within 2 To the comple	M	29b. Signature and title of certifier Mirzz A - Brig ND 743/15			(Month, Day, Year)
	í				3-24	-04
	H		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 15, S - Lencen Are, Marrede Grand 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 0 2 2004 Apr 6 2 2004	e, M	0,20	1078
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registr	ar	APR 0 2 2004 Canada / Aparla			

	4	State Unpend ITem#23a,	State of Ma	ryland / Dep	artment of I	Health and	Mental Hy	giene	1 1017
		Registrar 1. Decedent's Name (First, Middle, Last,		Ce	rtificate of	Death	2. Date of De		3. Time of Death
hysician		JENNIFER	LYN	WALKER			Month MARCH	Day Ye. 30.2004	
/Medical xaminer	r '	4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Dea		4c. County of D	
		2901 BOSTON STREET				LTIMORE		N/	'A
neral ector		5. Social Security Number 6. Security Number 214-92-7847	7. Age	(In yrs. last birthday) 27 Yrs.	Months Days		n. (Month, Da	0 40-7	Birthplace (State or Fore Country) [aryland
A TI	-	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Lim
in it	5	Md. n/a		Baltimor	е				1 (X)Yes 2 □ I
"natural; or itema 23a or 28a-1 enow saleal Examinar must be notified at letted by Funeral Director		10e. Street and Number 41 E. Heath Stre	et		10f. Zip Code 21	230		10g. Citizen of What U.S.A.	
dicer must		11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of I	Hispanic Origin? ((Specify Yes or No		merican Indian, /hite, etc.
Examina Fyring By Fu		1 Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	0	1 □ Yes 2 🗓 No		,	Specify:	
event, the Medical Exer event, the Medical Exer Be Completed by	pleic	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of w	rorking	16b. Kind of Busine	ss/industry
	5	10	0		omemaker			Но	me
even a	מ	17. Father's Name <i>(First, Middle, Last)</i> James F1	anklin	Wa	lker	18. Mother's Na Bet.h	ame (First, Middle,	, Maiden Sumame) Swing	
or other traumatic ever or other traumatic ever	=	19a. Informant's Name/Relationship (Ty Beth Walker	rpe, Print)	19b. Maili	ng Address (Street	and Number or F		er, City or Town, State	
other tr	-		(Mother)					e, Md. 21	
y or of	1	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 1 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	20b. Place of Dispo cometery, crea Bavview	natory or other pla Cremator		Date /03/04	Baltimore	
importent: If eny injury or once.	-	21. Signature of Funeral Service Licens			Name and Address McCu11	ess of Facility	iak Funer	al Home P	. A .
	+	23a Part 1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused t	the death. Do not ent	er the mode of dvi	no. such as cardi	ze. Balti ac or respiratory a	more, Md.	21230 Approximate
ysicien and the burial-transit to burial-transit	CYall	if any, leading to immediate cause. Enter Underlying Cause Colors as or injury		consequence of):					
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d by the attending priestached for use as the	ysicializm	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year
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page 2 should i	olliplete								
E 0 0	ו ע	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o		00 20110
v = .0	2	1 XYes 2 No	lospital: 1 🗌 Inpatien		IL SEL DOX		Home 5 ☐ Resid	dence 6 Other (S	pecify) AT SCEN
funeral funeral	5	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day		Wo	rk?	28d. Describe h	now injury occurred	
the the	Hilloan	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)		Yes 2 □No	28f. Location (S City or Tox	Street and Number or vn. State)	Rural Route Number,
e Funerel eletely filled		29a. Certifier 1 Certifying Physical Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of ner: On the basis of e and manner state	examination and/or in	n occurred at the till vestigation, in my o	me, date and place	ce, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
I 9 😤	ฆ์ ∟	29b. Signature and title of certifier	and manner state		29c. Licens	se number		29d. Date signed (Mo	onth, Day, Year)
o the Fune ompletely fil		_				CME			
c a 0		I him hi	, M.D			OCME		MARCH 31,	2004
complete	E	30. Name and address of person who co		ath (Item 23a) (Type,			, Baltimo	ore, Maryl	

			1 - For State Registrar	State of Mary			of He	aith and		al Hygie	_	_	10	178
	Dhusisi		1. Decedent's Name (First, Middle, Last,	- 11						ate of Death	Day	Yeer	3. Time of	Death
	Physici /Medic		Margare	WIL	1/a ma	S			3			004	0745	М
	Examin		4a. Fecility Neme (If not institution, give Sinai Hospital	street and number)		В	Baltır				4c. Cour NA	nty of Deeth		
	Funeral Director		5. Social Security Number 6. Security Number 217–34–3239	7. Age (In	yrs. last birthday) Yrs.	Months	1 Year Days	Hours M	lin. (A	ate of Birth Month, Dey, 1		9. Birthp Cour Va	olece (State or otry)	Foreign
poel	M N		10a. State 10b. County	100	. City, Town or Lo	ocation						1	0d. Inside Cit	y Limits
AL S	투	to	Md. NA		Baltimo	ore							1X Yes	2 🗌 No
1 3	28 8.728	Director	10e. Street and Number			10f. Zip	Code			100	. Citizen o	of What Cour	ntry?	
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200	tems let m	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decede	ent of Hisp ify Cuban,	anic Origin? Mexican, Pu	(Specify Y erto Rican	res or No- l, etc.)		ace - Americ lack, White,		
36	o ,	y F	1 Never Married 2 Married 3 🖫 Widowed 4 □ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1 ☐ Yes 2	No No	Specify:			Spec	ify: Bla	ck	
21215-0036	atura cat E	edt	15. Decedent's Edu		16a. Dece	dent's Usual	I Occupati	on		16	Sb. Kind of	Business/Inc	dustry	
215 24	Media Media	ple	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work DO NOT use	k done dui e retired)	ring most of v	working				,	
	ated Hygiene. event, the Medical Examinet must be notified at	Completed by	7th grade		Dome	estic							e Home	s
-	d off	Be	17. Father's Name (First, Middle, Last)				1		•	t, Middle, Me				
7	marked c	2	Phillip 19a. Informant's Name/Relationship (Ty		ristian	na Addrase	(Street on	Fat		te Number, (ith	Carla	
Z Za	Department of Health and Monte Department of Health and Monte Important: If Item 27 is marked any injury or other traumatic e once.		Mildred Morris	Niece		. Box				nt, Va		n, siaie, <i>zip</i> 23181	(000)	
ē,	f Heal		20a. Method of Disposition		b. Place of Dispo	sition (Nam	e of	i) Wes	Date			n - City or To	wn, Stete	
OL	nt: H		1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Mt. Carn	-		4-	2-04	Г	unda]	lk, Md		
Baltimore,	Departm Importa any inju	1	21. Signature of Funeral Service Licens	88		2. Name and		of Facility	R=	altimo			.202	
co 8	20 = 2		Meady	women	- 1	March	F.H.	East	11	Ol E.	Nort	h Ave.		
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Records, P.O. Box 687	× 9	Physiclan/Medlc	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pre						Date of delive	,	ear
rds, F	been signed be should be det	ρχ	Part II. Other significant conditions con Hyperseu	stributing to death but not	resulting in the u	nderlying ca	use given	in Part I.	_ 2		2 🗆 No		e cause of de ably 4 □Ur	
		Completed	- Diobetes	Melli	ng				-	4a. Was an autopsy performe □ Yes 2 ☑	d2/	Were autop prior to cor death? 1 \(\sum \text{Yes} \)	osy findings and pletion of call	vailable use of
Vision of Vital	certificate rector, pag	o Be	25. Was case referred to medical examiner?	lospital:	1/		Other	6. Place of D						
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ion	ath. r: Afte	atlo	1 Inatural 5 Pending 2 Accident investigation	(Month, Day Yee	r) Injury	м		s 2 🗆 No						
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Div	within 24 hours after To the Funeral Directorreletely filled in by	edical (29a. Certifier 1 F Certifying Physical Check only one)	sician: To the best of my ner: On the basis of exam and mamper stated.	knowledge, death nination and/or in	n occurred a vestigation, i	t the time, in my opin	date and pla ion, death oc	ice, and du courred at t	ie to the caus he time, date	se(s) and n and place	nanner as st , and due to	ated. the cause(s)	
Toth	withir To th comp	Me	29b. Signature and title of certifier	(/		29c.	License n	umber		29d	. Date sign	ed (Month, L	Day, Year)	
	h-) (H	m/a		1	019	407			3. 3	1.06	1	
			30. Name and address of person who co	empleted cause of death (Item 23a) (Type,	Print)		- 1.	Λ	D :	1	la .	dom.	-
d			31. Date filed (Month, Day, Yeer)	32. Registrar's S	2411	W. 1	Belvi	egiere	the	, 15a4	(Mire)	IND	21215	>
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<i>,</i> .			p	9.2.0.	
State of Marylan	d / Department of H	lealth and Me	ntal Hygiene 2	200	Chamberra

		1 - State Registrar			Cer	tificate of L	Jeath		Reg. N	lo.	
sicia edica		Decedent's Name (First, Middle, La Con		Mae	Za	worski		2. Date o Month Marcl	D	ay Year 2004	3. Time of Death 4:10 A
mine		4a. Facility Name (If not institution, gi	ve street and number))		4b. City, Town, or	Location of [Death		c. County of Dea	
		Genesis Heritage				Dunda		Hee I -		Baltimor	
ral tor			1□M 2⊠F	ge (in yrs. last b 64	Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month	Birth Day, Yea 16,1		hplace (State or Foreigr untry) rvland
100		Usuel Residence of Decedent 10a. State 10b. County		10c. City, To							-
	-			Toc. City, 10	WII OI LO	cation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Director	Maryland Ba	altimore			104 7in Code	Rei	stersto		2141	
		7 Kamaleer Cour	-+-			10f. Zip Code	2111			Citizen of What Co	•
	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	Was Decedent of Hi	2113	_	_	United S	
	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 ☐ Yes 2X☐ If Yes, Give Year or Dates:	No	1	Was Decedent of Hi f Yes, specify Cubai I □ Yes 2⁄2 No	Specify:	uerto Rican, etc.)	Black, Whit	e, etc.
		15. Decedent's E	ducation		a. Deced	lent's Usual Occupa	ition		16b.	Kind of Business/	hite Industry
	Completed	(Specify only highest gi	College (1-4or	5+)		kind of work done d 20 NOT use retired, memaker	luring most of)	working		Oran Hom	
	Be C	17. Father's Name (First, Middle, Las	t)			CIIIGIYCE	18. Mother's	Name (First, Mic	ldle, Maide	OWN HOM on Surname)	е 🧀
	To B	Andrew Klemm						Viol	.a Baı	rcowski	
	-	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailin	g Address (Street a	nd Number o				Tip Code)
		Andrea L. Zawor	ski/Daught	er	7 K	amaleer C	t. Ba	ltimore,	Mary	yland 2	1136
		20a. Method of Disposition		comet	of Dispos	sition (Name of natory or other place	9)	Date	20c. l	Location - City or	Town, State
		1 ☐ Burial 2 ☐ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Speci		·		Service C		/2/2004	7	rowson, 1	Marvland
		21. 5 vature of Funeral Service Lice	nsee	00	22. Di	Name and Addres Ida-Ruck 22 Wise	s of Facility Funera	1 Home o	f Dur	ndalk, I	nc.
700	1	Immediate Cause (Final	one cause on each li	ine.	not ente	er the mode of dying - O	, such as car	diac or respirator	y arrest, ¯		Approximate Interval Between Onset and Death
:	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CERES Due to (or as	a consequence BSTR a consequence TEXST	CE, e of): 1811 oul). UC	er the mode of dying R CAR TIVE	j, such as cai	diac or respirator	y arrest,		Interval Between
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** April 1, 2004 11:45 a M Sarah Evelyn Anderson /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Mariner Health Care of Laurel Laurel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb 1, 191 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2√₹ 217-09-4713 88 Delaware Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23s or 28s-f show treumatic event, the Mydical Examinar must be notified at 1 ☐Yes 2 ☐No Directo MD Prince George's Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9000 Briarcroft Ln. #101 20708 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status a filed within 72 hours after of Hygiene.

Hygiene.

other than *natural*, or itel 1 □ Yes 2 🖔 🖔 o If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXIo Specify Completed by 3 X XVidowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) of Health and Mental H litem 27 is marked off r other treumatic ever Be Pages 1 and 2 should be Viva Thawley Thomas Reihm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) New Windsor, Maryland 21776 granddaughter 14902 Hemp Ave. Eve Fisher 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 = 0 1 Burial 2 X remation 3 Removal from State permit. Page Department of Important: if any Injury or 4/5/2004 * 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 43/5 /M00770 313 Talbott Avenue Laurel, Maryland 20707 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heef failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Haemorrhagic Cerebrovascular Accident Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit or Attending Physicien: The law requires that the death certilicate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: esn esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No þ 4☐Pregnant at time of death 5 Other (specify) P.O. I PQ. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XMnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? X 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed page 2 No certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2XXVo 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 27. Manner of Death 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide hours after within 24 hours a To the Funeral Completely filled i the Hospitei 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie DO13687 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Magday 11701 Roby Avenue Beltsville, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 5 2004 Registrar

John Ray Andrews 04-01945

(04-01945)		Type or Print in Bi						ibie.	
I	MAN		1 - For Unpend Item#23a-1 Registrar		/04eg <i>Cer</i>	tificate of	Death	R	eg. No. 🕰 🔾	104	10181
	Physicia /Medic		Decedent's Name (First, Middle, Las John Ray An	drews				2. Date of Deat Month March	Dav	04	3. Time of Death
ad.	Examin		4e. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deal	th	4c. Count	ty of Death	
			1611 Olive Stre			Baltin					
7	Funeral Director			9X 7. Age (In yrs. las	st birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.		Year)	9. Birthp Coun	lace (State or Foreign try) MD
,	pur *		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation				1	0d. Inside City Limits
	e Maryla ta-f sho	ctor	MD N/A			timore C	ity				1 √2 ¥es 2 □ No
	h with the	ai Director	10e. Street and Number 1611 Olive St	treet		10f. Zip Code 21	230	1	0g. Citizen of	What Coun	itry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene item 27 is marked other than "natural", or items 23s or 28a-1 show other traumatic event, the Madical Examiner must be multipled at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed WOVOrced	12. Was Decedent Ever in U.S. Armed Forces? → Xes 2 □ No Arm If Yes, Give Year or Dates:	Y 13. V	Vas Decedent of H Yes, specify Cubi	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		ece - Americ ack, White, ify:	
15-0	in 72 ho "natur	Completed by	15. Decedent's Ec (Specify only highest gra		(Give	lent's Usual Occup kind of work done OO NOT use retired	during most of wo	orking	16b. Kind of E	Business/Inc	dustry
212	filed within Hygiene ther than "	шо	Elementary/Secondary (0-12)	College (1-4or 5+)		Mechan:			Aut	.0.	
B	illed in Hygie other	BeC	17. Father's Name (First, Middle, Last)	<u> </u>				me (First, Middle, I			
lan	ald be fental rked o	ToB	Clarence Andrew	vis			Els	ie	Unk.		
Maryland 21215-0036	d 2 should be th and Mental 7 is marked c traumatic ev		19a. Informant's Name/Relationship (19a. Betty J. Andrews					ural Route Number Pasadena		n, State, Zip	Code)
	s 1 and of Heatth item 27 other tr		20a. Method of Disposition	20b. Plac	ce of Dispos	sition (Name of			20c. Location		wn, Stete
Baltimore,	Page nent o ant: If ary or		1 ☐ Burial 2√5 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	//		v Cremato	ory 03/	/23/2004	Baltim	ore Ma	aryland
Ball	permit. Pag Department Important: I eny injury o		21. Signature of Euneral Service Licen	see Victor P. Doda,	Uk	Name and Addre arles L. St DI F Fort	evens Fund	eral Home, imore MD 2	Inc.		
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to minimidate cause. Enter Underlying Cause (Disease or injury)	a. Cirrhosis of the Due to (or as a conseque	Liver	ar the mode of dyir	ng, such as cardia	c or respiratory arre	est,		Approximate Interval Between Onset and Death
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ital		e e	25. Was case referred to medical				26. Place of De	ath (Check only on		/4500	
of Vital R	S 50	To B	examiner? XXYes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ Ef	P/Outpatien	3 DOA Oth	er: 4 🗆 Nursing H	Home 5 Reside	nce 6XOti	her (Specify	At scene
	ding h. After fune		27. Manner of Death 1XXINatural 5 Pending 2 Accident investigation	(Month, Day Year)	8b. Time of Injury	28c. Injur Wor M 1 🗆		28d. Describe ho			
Division	Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (St. City or Town		ber or Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tirestigation, in my o	ne, date and place pinion, death occu	e, and due to the ca urred at the time, da	use(s) and mate and place,	anner as sta , and due to	ated. the cause(s)
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier	$\bigcap I$ Λ		29c. Licens	e number	29	d. Date signe	ed (Month, L	Day, Year)
	, ,,,		ANA	vy /VI		0.C.	M.E.	N	March 1	19, 20	004
_			S. K. HOG	completed cause of death (Item 2	111		eet, Bal	timore, N	Mary lar	nd 212	201
	Sta Registr		31. Date filed (MgAPRY 0 5 20	04 32 Registrar's Signatur	re de	and a					

		í	1 - For State Registrar	State of M	arylan	id / Depa <i>Cei</i>	artmen rtificate	t of H e <i>of L</i>	ealth a Death	and M		giene Reg. No. 2 (004	10182
	Dhuaiai		1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medio		ANELIA	LEATRIC	Œ	ADKINS					MAR	30 20	04	1:19 P M
	Examin	er	4a. Facility Name (If not institution, giv			D	4b. City,		Location of				ty of Deeth	frant.
			NATIONAL NAVAL 5. Social Security Number 6.5			last birthday)	If Under		THESD If Under		8. Date of Birth		ONTGO	
٨	Funeral Director			1 ☐ M 2√2 F		54 Yrs.	Months	Days	Hours	Min.	(Month, Da) Aug 7,	r, Year)	Vir	place (Stete or Foreign ntry) ginia
			Usual Residence of Decedent								1106 7 9			5-11-14
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	Od. Inside City Limits
	Ba-1 s	cto	VA Fairfax		<u></u>	Fairf			n					1 ☐ Yes 2 ☐ No
	or 2	Dire	10e. Street and Number	D.7			10f. Zip					10g. Citizen o	f What Cour	ntry?
	s 23s	ra	7917 Hollington	Place 12. Was Decedent	Consin II	6 42.1		2039		-:-2 (0	aifu Vaa aa Na	USA	ace - Americ	nen Indian
	Item Item	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces	?	.5.	f Yes, spec	offy Cuba	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		ack, White,	
936	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	7		1 ☐ Yes	2 XNo	Specify:			Spec	eify:	Black
Ŏ	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f show he Medical Examirar must be notified at	Completed	15. Decedent's E (Specify only highest gra			16a. Dece	dent's Usua kind of wo	al Occupa	ation	t of worki	na	16b. Kind of	Business/In	dustry
2	Ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us	se retired)					
7	led w lygier her th		47 February News (February Middle Asset)	6		Spec	ial E	duca			her (First, Middle,	Publi		ools
Maryland 21215-0036	be fi	Be	17. Father's Name (First, Middle, Last James Irwin Ande							el L		маюн эита	ime)	
<u>=</u>	d Men mark matic	²	19a. Informant's Name/Relationship (19h Mailir	na Address	(Street a			i Route Numbe	r City or Tow	n State Zin	Code)
<u>≅</u>	id 2 s ith an 27 is trau		Ronald A. Adkins		1		_				Fairfax	•		
re,	s 1 ar I Hea Item	1 3	20a. Method of Disposition		20b. F	Place of Dispo cemetery, crer	sition (Nan	ne of	T	-	ate	20c. Location		
E G	Page ient o nt: If ry or		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special			ins Fa				4-6	-04	Rocky	Mount	, VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show amy injury or other traumatic event, the Medical Examinat must be notified at Once.	- 4	21. Signature of Funeral Service Lice	nsee	0	22	. Name an	d Addres	s of Facilit	y	1 Home,	Tnc		
<u>m</u>	88 2 2 8		Muy. ux	16 Jost				P.O.	Box	3633	Warren	ton, V	A 2018	38
	W. 3		23a Parti. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each I	d the deat	h. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory are	rest,		Approximate Interval Between Onset and Death
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Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Feta	Ideath 3□	Ectopic pr						ate of delive	ery Day Year
	that the death cer ed by the attendir detached for use	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4□Pregnant a 9□Unknown	it time of a	eath 5	Other (sp	өспу)				í		
P.0	law requires that the as been signed by th 2 should be detache		Part II. Other significent conditions	contributing to death I	out not res	ulting in the u	nderlying c	ause give	n in Part I.	,	23e. Did to	bacco use co	ntribute to th	e cause of death?
Vital Records,	quires n sigr uld be	d by	 								1 □ Y	es 2 📉	3 Prob	ably 4 Unknown
000	aw requir is been si 2 should	olete									24a. Was a	an 24b	. Were auto	psy findings available
Re	The lay ate has bage 2	Completed									autop: perfor 1 X Yes	sy med? 2 □ No	death?	npletion of cause of 2 No
ita		Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or			
of <	Physicien: r this certific ral director.	2	1 ☐ Yes 2 ☐XNo	Hospital: 1X Inpati		ER/Outpatien			4 140	rsing Hor	ne 5 🗆 Resid	ence 6 🗆 O	ther (Specify	()
	ding P th. After t funera	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Yeer)	28b. Time of Injury		8c. Injury Work			28d. Describe h	ow injury occu	irred	
Sic	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	De Diese et le	iunz . At h	omo form etc	M oot factors		/es 2 □ I		ost Location (S	troot and Alum	hor or Pres	l Route Number,
Division		Certification:	4 Homicide determined	building, e			eer, ractory	, once			City or Town		ibai oi nura	r noute reamber,
1	To the Hospital or Attan within 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Pl	hysicien: To the best	of my kno	wledge, death	occurred	at the tim	e, date an	d place, a	and due to the c	ause(s) and n	nanner as st	ated.
e	n 24 h	edical	(Check only 2 2-Medical Examone)	miner: On the basis of and manner si	of examina tated.	tion and/or in	vestigation,	, in my op	pinion, dea	th occurre	ed at the time, d	late and place	, and due to	the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier	01		2		. License			2	29d. Date sign		
I	34		100m011.	Mone	KER	mr.)	D-00	43443	B		311	burch	2004
1	- F		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type,	Print)				NAVAL I			ER
			JOHN M. CHAN 31. Date filed (Month, Day, Year)	DLER CDR 32. Regist	MC	USN	·			ESDA	MD 208	89~5600)	
	Sta Registi		APR 0 5 200		المحاصرة	B	Lon	1.200	0'					

ROSE AUS 04-2221 DAP

			State Unpend Item#23:	state of Ma a,27,28a f,Per	and Dep	artment of H Vieg rtificate of L	ealth and M Death	lental Hyg	giene200	4 10183
	Dhysisi	*	1, Decedent's Name (First, Middle, L	ast)				2. Date of Dea Month	Day Yee	3. Time of Death
	Physici /Medio		Rose Aus				. 3233	MARCH 3		8:16a M
2	Examir	er	4a. Fecility Name (If not institution, ging GREATER BALTIMOR	E MEDICAL (CENTER	TOWSON	Location of Death		4c. County of D BALTIM	ORE
1/20	Funeral Director		5. Social Security Number 6. 220-54-8047	Sex 7. Ag 1 ☐ M 2X F	e (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Dey Dec . 9		Birthplace (State or Foreign Country) Maryland
/	pun *		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	h the Maryland rr 28a-f ehow Lrottfled at	ō	MD Baltin	one	Cockeys					1 ☐ Yes 2 🗷 No
	28a-1	Director	10e. Street and Number	101.6	Luckeys	10f, Zip Code	· · · · · · · · · · · · · · · · · · ·		10g. Citizen of What	Country?
	death with the Maryland ms 23a or 28a-f ehow fritted by frottilled at	Ö	5 Dulaney Gate	Court		2103	30		United 9	States
		Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of His	spanic Origin? (Sp	ecify Yes or No-		merican Indian,
336	a o E	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced		No	1 ☐ Yes 2 ☑ No	Specify:	Thous, Go.,	Specify:	White
2-0	72 hours "netural", adical Ex	Completed	15. Decedent's (Specify only highest of		(Give	dent's Usual Occupa	luring most of work	ina	16b. Kind of Busine	ss/Industry
2	d within 2 giene. or then "r	npie	Elementary/Secondary (0-12)	College (1-4or 5	i+) life.	DO NOT use retired)				
121	lied w tygier her th		17. Father's Name (First, Middle, Las	21)	Home	emaker	18 Mother's Name	e (First Middle		Home
Maryland 21215-0036	uld be fi Mental H irked ot itic ever	To Be	August J. DePas					Naomi A		
lan	2 sho and I ie mu		19a. Informant's Name/Relationship						r, City or Town, State	
	and lealth m 27 har tr		Mr. Frederick A	us/husband	5 Du.	laney Gate			ville, MD	
Baltimore,	Pages 1 nent of H int: If ite iry or otl		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 ☒ Other (Spec		cemetery, cre	matory or other place Valley Me	°) 04/0	5/2004	20c. Location - City Timonium	m, Maryland
Balti	permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "n eny injury or other traumatic event, the Medions."		21. Signature of Funeral Service Lic	\$1560	2:	2. Name and Addres			on Funera: Maryland	l Home, Inc. 21204
	5		23a. Pert1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do not en					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_	te Intoxicati	.on				Onset and Death
	/Medical		resulting in death)	a	a consequence of);					
B	Examiner		Sequentially list conditions,	b						
19.00	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of tested of the tributation of the cause of tested of the tributation of tr	Due to (or as	a consequence of):					
,00	cate be executed physician and the burial-transit	i Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
8760,	cate b physic the b	dlcai	•	d						
D. Box 6	The law requires that the death certifulate has been signed by the attending I page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ሺ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
P.0	es that the digned by the be detached	, Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	inderlying cause give	in in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
Vital Records,	n sign	d by		·				1 □ Y	es 2 No 3	Probably 4 Unknown
CO	aw require is been si 2 should b	Completed						24a. Was a		autopsy findings available
R	The la	E O						autop: perfor	med? death	to completion of cause of i? 'es 2 \(\sum \text{No} \)
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat	7/201		
>	N S D	2	1X Yes 2 No	Hospital: 1 Inpatie		nt 3 DOA Othe	4 Nursing Ho	me 5 🗆 Resid	ence 6 Other (S	pecify)
ū	ding P	on:	27. Menner of Death 1 □Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year) Injury	Work	?		ow injury occurred	
Sio	Attending Physician: r death. sctor: After this certifics by the funeral director, I	cat	2 ☐ Accident investigate 3 ☑ Suicide 6 ☐ Could not	be One Place of Ini					ngested drug	Rural Route Number,
Division of	or At after of Direction by	Certification:	4 ☐ Homicide determine	building, et	ury - At home, farm, st c. (Specify)	геет, гастогу, опісе		City or Town	n, State)	ckeysville, MD
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai C	(Check only 25 Medical Ex	Physician: To the best	examination and/or in		e, date and place,	and due to the c	ause(s) and manner	as stated.
	within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner sta	ated.	29c. License	number	2	29d. Date signed (Mo	onth. Dev. Year)
	T W			5. M.D		OCME			APRIL 1,20	
			30. Name and address of person wh		eath (Item 23a) (Type					-
			LING LI	M.D	(200/ (1/00/		Street, 1	Baltimor	re, Maryla	and 21201
	Sta	_	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	marks o				
	Regist	air		BARRETT CAN	The same of the sa	and the same of th				

			1 - For State Registrar	State of Mary		artment rtificate				Reg. No. 2	004	10184
	Physici /Medi	al	Decedent's Name (First, Middle, Last, Phyllis Bower Aa. Fecility Name (If not institution, give)	S		4b City 1	Town or	Location of Dea		30, Day 200	04 Year	3. Time of Death 12:37 A M
	Examir	er	10049 Ichobod Lar 5. Social Security Number 6. Se	ne	yrs. last birthday)	Balt	imo			Balt	imore	
	Funeral Director			M 2 🛣 56		Months	Days	Hours Mir	June 23	ay, Yeer)		place (Stete or Foreign intry) Yland
	e Maryland	ector	10a. State 10b. County MD Baltimore		c. City, Town or Lo Baltimo	ore						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
g G	be filed within 72 hours after death with the Maryland lat Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10049 Ichobod Lar 1. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No		Was Deceded	.220 ent of Hi ify Cubar		Specify Yes or No rto Rican, etc.)		Race - Amen Black, White	ican Indian, , etc.
21215-0036	within 72 hours a ene. than "natural", c he Medical Exa	Completed by	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad	If Yes, Give Year or Dates: Ication (a completed) College (1-4or 5+)	16a, Dece	1 ☐ Yes 2 dent's Usual kind of work DO NOT use	I Occupa	Specify: tion uring most of w	orking	Spe		white
	d be filed will sntal Hygiene ted other tha c event, the	Be	12 17. Father's Name (First, Middle, Last) Frederick P. Ste	2	N	Mail C		inator 18. Mother's Na Irma E.	ame (First, Middle		Firm	
nore, Maryland	ges 1 and 2 should by of Health and Menta if item 27 is marked or other traumatic every	To	19a. Informant's Name/Relationship (T) William Bowers − 20a. Method of Disposition 1∑ Burial 2 □ Cremation 3 □ F	npe, Print) husband Removal from State	10049 Ob. Place of Disponsion of the Computery, crem	Icho sition (Nam	(Street a bod e of her place	nd Number or F	Rural Route Numb Baltimore Date	20c. Locatio	21220 n - City or T	own, State
Baltimore,	permit. Pages Department of I- Important: If its any injury or of		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		Meadowrid Ga 72	Name and	Address Kau	s of Facility Ifman Fu	03/04 meral Ho .vd., Elk	Elkrio me at Mo ridge.	eadowr	TD ridge MP, Inc 21075
8760,	Physician /Medical Examiner this prints-fransit Physician and P	lical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor Due to (or as a cor Due to (or as a cor	nsequence of): Jator nsequence of):	<u> </u>	F3	Feel	Sclo) 05 C	2	Approximate Interval Between Onset and Death
.O. Box 68	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Vo 9 Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 [Ectopic pre					Date of deliver	ery Day Year
ords, P	The law requires that the ate has been signed by the page 2 should be detache	by	Part II. Other significant conditions con	ntributing to death but no	t resulting in the u	nderlying ca	use give	n in Part I.	23e. Did t	./		he cause of death?
Vital Record	The farate has	Completed							1 Tes	psy prmed? 2 No	prior to co death?	ppsy findings available impletion of cause of
Division of Vit	iing Phys After this funeral di	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 to 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 5 Could not be	28a. Date of Injury (Month, Day Yea		28 M	Othe Bc. Injury Work' 1 Y	r: 4 ☐ Nursing	Home 5 Result 28d. Describe	dence 6 🗆 O	urred	
Divi			4 Homicide determined 29a. Certifier 1 Certifying Phy	28e. Place of Injury - building, etc. (Sp. sician: To the best of my	pecify) r knowledge, death	occurred a	at the time	e, date and place	City or Tou	wn, State)	manner as s	al Route Number,
)	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Exami	ner: On the basis of exar and manner stated.	mination and/or in	estigation,	License	inion, death occ	urred at the time,	date and place	e, and due to	o the cause(s)
× 4	\bgreen \square Sta		30. Name and address of person who co SCOTT WEIGH 31. Date filed (Month, Day, Year)	T MD 32. Registrar's S	JOHNS Signature	HOPK	INS		DUM:	DALK,	MAR	YLAND
3	Registi	ar	APR 0 5 20	U4 /		11						

				For State Registrar	State of Maryland / I	Department of Certificate	of Health and I of Death	Mental Hygien	/!!!!!	10185	
	H	Physicia /Medic	al	Decedent's Name (First, Middle, Last, He 4a. Facility Name (If not institution, give	VRV R. (SROWN 4h Gir To	wn, or Location of Death		Year O 2004	3. Time of Death 9:22 p M	
		Examin Funeral	er	UPPER CHESA PE 5. Social Security Number 6. Sec	TAKE MEDICAL	nthday) If Under 1 Y		8. Date of Birth	11AR-FOR	ece (State or Foreign	
		Director		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location	24/	12.13.19		d. Inside City Limits	
	death with the Maryland	or 28a-f show e notified at	Olrector	10e. Street and Number	0	+BINGD	de	10g. C	tizen of What Count	1 □ Yes 2 🗓 🚧 6	
	9		by Funeral Director		I. Was Decedent Ever in U.S. Ampd Forces? 1 ■Yes 2 □ No If Yes, Give Year or Dates:		2/009 tof Hispanic Origin? (Sl Cuban, Mexican, Puerto No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e Specify: BL	n Indian, tc. 9CK	
X123	d 21215-0036 filed within 72 hours after	natur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)	cation 16a	Decedent's Usual C (Give kind of work of life. DO NOT use r	none during most of work etired)	<i>U</i>	ind of Business/Indu	·	
V	ryland	and Mental Hygiene. Is marked other than aumatic event, Its M	To Be	17. Father's Name (First, Middle, Last) SYLVESTEX	ASTON		DOKE	THEA B	KOWN		
40	re, Mal	f Health item 27 other tr		20a. Method of Disposition	SLOWN /WIFE 2	. Mailing Address (Si DSS (I Disposition (Name or or other	NOTTY PIN	Tal Route Number, City EDRIVE Date 20c. L		1, MD 21009	
3/30/04	E ge	ent: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	MD NA	TIONAL CEM	ETERY 4.5 ddress of Facility P	5.04 LAN USHN C.GI BACTIMON	REL, MI REENE FOR	IERAL HOME	
#414273	8760, ate be executed Π	hysicia the bur	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence)	of): & of): ? Cer				Approximate nterval Batween Onset and Death 18 Days 18 Days 18 Days 18 Months	
J. Ky	Records, P.O. Box 60 The law requires that the death certific	2 2	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐Ectopic pregn 5 ☐ Other (specif			23d. Date of delivery Month D	y Yay Year	
TEN	ecords, P	igne be o	þ	Part II. Other significant conditions cor Brain Metas		the underlying cause Renal Pa	-1		use contribute to the		
1,5		certificate has be rector, page 2 sh	Completed					24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	prior to comp death?	y findings available bletion of cause of	
SOWA	of Vital Physician:	is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 \(\text{npatient} 2 \subseteq ER/Ou	tpatient 3 DOA	04	th (Check only one) ome 5 - Residence	6 DOther (Specific	*	
3 R.C.		leath. tor: After this the tuneral di		27. Manner of De th 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. 1	Time of 28c.	Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inju			
1-4	Division tel or Attending	within 24-hours after death To the Funeral Director: , completely tilled in by the t	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rura City or Town, State)							
-	the Hospitei	within 24-hour To the Funer completely till	edical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	sicien: To the best of my knowledge ner: On the basis of examination and and manner stated.	, death occurred at the d/or investigation, in r	ne time, date and place, ny opinion, death occur	and due to the cause(s) red at the time, date and	and manner as stat place, and due to the	ed. ne cause(s)	
	To	To t		29b. Signature and title of certifier Moreo Han	ne		H0819		e signed (Month, De ch 30, 20		
	\	2		30. Name and address of person who co		Type, Print)		16.42	10161		
	*	Stat Registra	G	31. Date filed (Month, Day, Year) APR 0 5 2004	32. Registrar's Signature	Ann de	c unve, be	lAir, MD 2	1017		

1	Tidade Type of Time in Diade interior in a Diade Air Edg	ioic.	
pend	State of Maryland / Department of Health and Mental Hygiene 1 item#23a-d,2/,PR ME,6830,4/30/2008	104	10

RJD			State of Maryland / Depar State unpend item#23a-d,27,PFR MC,0830,4/30/0/e Registrar	ment of Health and Ficate of Death	Mental Hygi	iene2004 10186
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Jaunet Dea Broussard		2. Date of Death Month April (Day Year
	Examir		4a. Facility Name (If not institution, give street and number) Carroll Hospital Center	b. City, Town, or Location of Dea Westminster	ath	4c. County of Death Carroll
34/18	Funeral Director		213 55 1853 1□M 2໘F 5 Yrs.	If Under 1 Year If Under 24 Hi Months Days Hours Mi		Year) 9. Birthplace (State or Foreign Country) Maryland
, —	show	7	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	ith the Marylar or 28a-f show	Director	MD Carroll Westminster	10f. Zip Code	10	Dg. Citizen of What Country?
	h with		628 Bear Branch Road	21157		United States
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then the marked other than "natural", or itema 23e or 28e-f show other traumatic event, its Medical Examental beau willed at	by Funeral	1X Never Married 2 ☐ Married 1 ☐ Yes 2X No	s Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pue Yes 2 140 Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	vithin 72 ho ne. han "natu	Completed	(Specify only highest grade completed) (Give kin life. DC) Elementary/Secondary (0-12) Coltege (1-4or 5+)	it's Usual Occupation of of work done during most of w NOT use retired)	orking 1	16b. Kind of Business/Industry
d 2	filed v Hygie other t		0 N/A 17. Father's Name (First, Middle, Last)	18. Mother's N	ame (First, Middle, M	N/A faiden Sumame)
lan	should be nd Mental marked o	To Be	Stephen A. Broussard		Jean Booke	,
Mary	and 2 should be filed within balth and Mental Hygiene. n 27 is marked other than har traumatic event, I.a.M.			Address (Street and Number or F		
Je,			20a. Method of Disposition 20b. Place of Dispositi			20c. Location - City or Town, State
Ë	Pages ment of H ant: If ite ury or of		'4 Donation 5 Other (Specify) Good Shepl	nerd Cem. 4-	7-2004	Ellicott City, MD
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr 20Cs.					tzke's Family FH Inc. icott City, MD 21043
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia	he mode of dying, such as cardi	ac or respiratory arre	st, Approximate Intervat Between Onset and Death
4	Examiner		Due to (or as a consequence of): Dehydration b.			
	ecuted ind transit	Examiner	cause. (Disease or injury that initiated events			
68760,	ficate be executed g physician and as the burial-transit	edical Ex	Due to (or as a consequence of): Viral Syndrone			
P.O. Box 6	ne death certi the attending thed for use a	Physician/Med		etopic pregnancy ther (specify)		23d. Date of delivery Month Day Year
rds, P	quires that the signed by ald be detacted	by	Part II. Other significant conditions contributing to death but not resulting in the unde	rlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
Division of Vital Records,	iysicien: The law requi is certificate has been s director, page 2 should	Completed			24a. Was an autopsy perform	prior to completion of cause of death?
Vit	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical axaminer? 1 ★ Yes 2 No Hospital: 1 Inpatient 2 ★ ER/Outpatient	04	eath Check only one	nce 6 Other (Specify)
ion of	nding Phy th. : After this s funeral c	tion; T	27. Manner of Death 1 S Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	
Divis	al or Attendi s after death. Il Director: A id in by the fu	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	To the Nospital or A within 24 hours after To the Funeral Direction properties of the Funeral Direction of the Post of the	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death or the basis of examination and/or investigation and manner stated.	curred at the time, date and place ligation, in my opinion, death occ	ce, and due to the cau curred at the time, gat	use(s) and manner as stated. te and place, and due to the cause(s)
		Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		d. Date signed <i>(Month, Day, Year)</i> April 03, 2004
40	* PERIL)		30. Name and address of person who completed author of death (Item 23a) (Type, Printing A. H. C. A. A. H. C. A.	111 Penn Str	eet, Balt:	imore, Maryland 21201

Registrar

APR 0 5 2004

B.K.S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

TID TELL 1 (E100)		o type of think in
JUDITH MEADS	BURKHARDI'	State of Maryla
4	For	State of Maryta

Maryland / Department of Health and	Mental Hygiene	1010
Maryland / Department of Health and Certificate of Death	Reg. No. ZUUL	10187

			For State Registrar		rtificate of Death	Reg.	711116	10187
	Physici /Media			chardt		2. Date of Death Month APRIL	Pay 2004 ^{ear}	3. Time of Death 0553 A M
	Examir	er		MILEPAST ROUTE#29	4b. City, Town, or Location of Death MERRITSVILLE		4c. County of Death HOWARD	1
**************************************	Funeral Director		215-90-3930	7. Age (In yrs. last birthday) M 2XIF 39 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye July 6, I	9. Birth 1964 Mar	nplace (State or Foreign (Yland
	the Maryland 28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County	^e Phoenix	ecation			10d. Inside City Limits 1 ☐ Yes 2 ☐ KNo
	th with the 23a or 28 ist be no	Funeral Director	10e. Street and Number 14608 Woodbark	Lane	10f. Zip Code 21131	10g.	Citizen of What Cou	untry? USA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatib and Mental Hygiene. Department: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified a any injury or other traumatic event, the Medical Examiner must be notified a once.	by	11. Marital Status 1X Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2X□No	Was Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto F 1 Yes 2 No Specify:	cify Yes or No- tican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
215-0	within 72 ho lene. than "natur he Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	dent's Usual Occupation kind of work done during most of workin DO NOT use retired)	g 16b	Child of Business/I	
Maryland 21215-0036	12 should be filed within hand Mental Hygiene. 7 is marked other than "riraumatic event, the Mad	To Be Cor	17. Father's Name (First, Middle, Last) Louis Burkhard		Care Worker 18. Mother's Name Gwendo		Child Ca den Sumame) deshel	ire
	and 2 shoul alth and Me 27 is mari ar traumati	Ţ	19a. Informant's Name/Relationship (Ty Mrs. Gwendolyn Bur		ng Address <i>(Street and Number or Rural</i> 08 Woodbark Lane Pl	Route Number, Ci		ip Code)
Baltimore,	Pages 1 and the ment of He ment: If item ury or other		20a. Method of Disposition 1 XBurial 2 Cremation 3 R 4 Donation 5 Other (Specify)		sition (Name of natory or other place) Episcopal 4-4-0		nkton, Mo	
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service License	22	Ruck Towson Facility uner 1050 York Rd. Tow	al Home, son, Md.	Inc 21204	
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not ente				Approximate Interval Between Onset and Death
	Examiner publications	miner	Sequentially list conditions, fary, learning to minimaliar cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):				
68760,	rificate be executed ng physicien and as the burial-transit	Medical Examiner	resulting in death) Last	Due to (or as a consequence of):				
.O. Box 6	death ce e attendii id for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 X Unknown		Ectopic pregnancy Other (specify)		23d. Date of delive	rery Day Year
<u>α</u>	equires en sign ould be	þ	Part II. Other significant conditions cor	tributing to death but not resulting in the ur	nderlying cause given in Part I.		2 No 3 Pro	the cause of death? bably 4 □Unknown
Œ.	The ate ha	Completed				24a. Was an autopsy performed 1 Yes 2	? prior to co	opsy findings available ompletion of cause of 2 No
f Vital	Physician: The this certificate har ral director, page	To Be	25. Was case referred to medical examiner? 1 XYes 2 No	ospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death		6 XXX ther (Speci	fy) AT SCENE
_	ing Ph Viter th uneral	atlon: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 4-1-04 5:44 A	28c. Injury at 28 Work?	d. Describe how in	njury occurred	ja mota vehic
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	· · · · · · · · · · · · · · · · · · ·	ad B	ethang Lan		East of d mD
)	e Hospital or 24 hours afte Funeral Dii etely filled in	dical	29a. Certifier 1 Certifying Physical Check only 2 Nedicel Examination	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, an	nd due to the cause	e(s) and manner as s and place, and due t	stated. o the cause(s)

State

111 Penn Street, Baltimore, Maryland 21201 M.D 32. Registrar's Signature

Registrar

29b. Signature and title of certifier

LING LI.

hi.

m.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) APRIL 1, 2004

State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 30 Martha R. Bynum March 2004 9:00 A /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1405 Fernhill Court Forestville Prince George's 8. Date of Birth (Month, Day, Year) 02/17/1911 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 93 Yrs. 1 □ M 2 X F Director 088-26-3957 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If itsm 27 is marked other then "natural", or itema 23e or 28a-1 show any Injury or other traumatic avant, the Modical Examiner must be notified at once. 1 Yes 2 No Completed by Funeral Director <u> Maryland | Prince George's</u> Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 1405 Fernhill Court USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes XX No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Clerical Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Josephine Essex George Robertson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karen Balma / Daughter 1405 Fernhill Court Forestville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/03/2004 Landover, Maryland Harmony Mem. Park Cem. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Septice Licensee 22. Name and Addre Se бастире Р. Kalas Funeral Home Р.А. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition INFARCTON Priysician TYOCARDIAL resulting in death) /Medical **Examiner** CARDIOVASCULAR ATHEROSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ eq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown METASTASIS CF UMKNOWA Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 ☐ Yes 🛛 🗓 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 51 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Alter this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Matural investigation 1 ☐ Yes 2 ☐ No 2 Accident death the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Victor Herry MD 20986 30. Name and address of person who completed cause of a ath (Item 23a) (Type, Print) 3-31-2004 PISCATAWAY 9131 Rol LINTOH MD 31. Date filed (Month, Day, Year) APR 0 5 2004 32. Registrar's Signature

Registrar

		1 - For State Registrar	State of Marylar		artment of rtificate of			giene Reg. No 2004	10189
Physi	cian	Decedent's Name (First, Middle, La		7 -			2. Date of Dea Month	Day Year	3. Time of Death 4:00 P M
/Med Exam	lical	4a. Facility Neme (If not institution, giv	Charles Howa	ira Be	4b. City, Town,	or Location of De		30,2004 4c. County of Dea	
Funera Directo	ıl e	Johns Hopkins Bay 5. Social Security Number 6. S	view Medical C				rs. 8. Date of Birt	N/ h 9. Bir y, Year) C	A thplace (State or Foreign ountry) messee
ō	,	Usual Residence of Decedent					1100. 10	7,1323 10	
e Marylan 3a-f show	Director	Maryland Bal	timore 10c. Ci	ty, Town or L	ocation	Dundalk		ARP	10d. Inside City Limits 1 ☐ Yes 21∑ No
with the or 24		10e. Street and Number			10f. Zip Code	2122		10g. Citizen of What Co United S	
Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic avent, the Medical Exercise must be retilised.	Funeral	500 Southern Av 11. Marital Status 1 Never Married 263 Married	12. Was Decedent Ever in U Armed Forces? 153/es 2 No If Yes, Give		Was Decedent of If Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White	erican Indian, te, etc.
21215-0036 ad within 72 hours all giene. er than "natural", or , the Medical Exert	Completed by	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gri	Year or Dates: WW	16a. Dece	dent's Usual Occi	upation	vorking	16b. Kind of Business	White /Industry
within ene.	dmo	Elementary/Secondary (0-12) 5 Years	College (1-4or 5+)		DO NOT use retir	,		Steel Ind	ustry
land 2	To Be Co	17. Father's Name (First, Middle, Last Rubin Berry)	1011	11110 01	18. Mother's N	lame (First, Middle, Ida Young		
Maryland and 2 should be file alth and Mental Hy 27 is marked oth		19a. Informant's Name/Relationship (Barbara D. Cram			ng Address <i>(Stree</i> Southerr			r, City or Town, State, . Maryland	Zip Code) 21224
Baltimore, Dermit. Peges 1 at Department of Hea mportant: If item		20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ ☐ Donation 5 ☐ Other (Special	Removal from State	cemetery, cre	osition (Name of matory or other pl n Cemeter		Date 2004	20c.Location - City or Baltimore	Town, State , Maryland
Balti permit. Departm Imports any inju		21. Signature of Funeral Service Lice	and					Dundalk, I	nc. 1222
3760, ate be executed Thysicien and the burial-transit	1	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to ammediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect b. Due to (or as a consect c. Due to (or as a consect c.	quence of):	ANGURY	5 M			Interval Between Onset and Death Fire 4800
BOX 66. death certific e attending pl	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn- 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c	al death 3[⊒Ectopic pregnan ⊒ Other (specify)	су		23d. Date of del Month	livery Day Year
Records, P.O The law requires that the ten bas been signed by the bage 2 should be detached.	by	Part II. Dther significant conditions	contributing to death but not res	sulting in the u	underlying cause g	iven in Part I.		bacco use contribute to	o the cause of death?
	Completed						24a. Was autop perfor	sy prior to death?	utopsy findings available completion of cause of
of Vital F Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	1		thee	eath (Check only o		
ng Phy fter this	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inj	4 🗀 Nursing		ence 6 □Other (Spe ow injury occurred	cify)
Division of or Attending s after death. It Director: After si in by the fune	Certification:	3 Suicide 6 Could not be determined		ome, farm, st (y)	reet, factory, office)	28f. Location (S City or Tow	treet and Number or Run, State)	ural Route Number,
Divisio To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the tu	edical (29a Certifier 1 Certifying Pl (Check only one) 2 Medical Exam	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, deat ation and/or in	th occurred at the overtigation, in my	time, date and pla opinion, death oc	ce, and due to the c curred at the time, o	ause(s) and manner as date and place, and due	s stated. to the cause(s)
To the To the comp	ž	29b. Signature and title of certifier				se number		29d. Date signed (Mont.	- 41
11		Hy Cocor	THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TW			000555	77	APRIL 1,	2004
1011		30. Name and address of person who ルギャヤー CAC ACINO JN 31. Date filed (Month, Day, Year)		036LL 1	Print)	BALT	imore m	ARYLAM	21236
Regis	itate strar	4PR 0 5 2004	han ha	lon.	W. 1				

		1 - For State Registrar	State of Mar			artment of He tificate of D			tal Hygie Reg	ene 3. No. 20	04	1019
Physic /Med		1. Decedent's Name (First, Middle, La SANKARAW	CHANDRA	SEKH	AR	AN		l N	ate of Death Month	Day	Year LOOY	3. Time of Death
Exam		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or BETHEOUN	Location	of Death		4c. County of		ヺ
Funera Directo		466-51-7521	ex 7. Age	(In yrs. last birt	hday) (rs.	If Under 1 Year Months Days	If Under Hours	Min. (/	ate of Birth Month, Day, Y		9. Birthpl Coun Ind	ace (State or Foreig try) 1a
show	ž	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town							10	0d. Inside City Limits
vith the M or 28a-f	Director	Maryland Montgom 10e. Street and Number	ery	Gai	the	rsburg 10f. Zip Code			100	g. Citizen of W	hat Coun	
within 72 hours after death with the Maryland liene. Then "natural", or Items 23a or 28a-f show the Maryland Than That the Maryled Examine must be notified at	by Funeral	15 Travis Court 11. Marital Status 1 Never Married 27 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			2087 Vas Decedent of His Yes, specify Cuban ☐ Yes 2∏ No						an Indian, etc.
d within 72 hours af giene. er than "natural", or the Medical Exam	Completed t	15. Decedent's E. (Specify only highest gra Elementary/Secondary (0-12)	fucation)	(Give life. L	ent's Usual Occupa kind of work done du OO NOT use retired)	<i>iring</i> mos	st of working	16	6b. Kind of Bus	iness/Ind	
9 0 0	Be	17. Father's Name (First, Middle, Last)		5	OIL	ware Engi	18. Moth	er's Name (Firs				
s 1 and 2 should f Health and Men itam 27 is marke	5	Sankaran Krishnan 19a. Informant's Name/Relationship (Swathi Chandrasek	Type, Print)			g Address (Street a	nd Numb		ite Number, (City or Town, S		Code)
	5	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific	Removal from State	20b. Place of cemetery	Dispo: v, crem	avis Cour sition (Name of natory or other place e Cremato)	Date	20	c. Location - C	City or To	
permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Liber	Down		S 1	Name and Address mple Trib 40 Rockvi	of Facili	_{ty} Funeral	and C	remati	on Co	enter
Coate be executed Physician and Physician and Bhysician and sthe burial-transit	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line	consequence o	():	n no nous or dying			onatory arres			Approximate Interval Between Onset and Death
death certif e attending ed for use a	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. d. 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death		Ectopic pregnancy Other (specify)				23d. Date Mont		Y Day Year
, 5 b b	by	Part II. Other significant conditions of DIVAGE TES, HYP		not resulting in	the un	derlying cause giver	in Part I	. 2			oute to the	e cause of death?
age age	Completed								4a. Was an autopsy performe ☐ Yes 2	pri de de	ere autop or to com ath? Yes 2	sy findings available pletion of cause of 2□ No
i or Attanding Physician: The after death. Director: After this certificate in by the funeral director, pag	atlon: To Be	25. Was case referred to medical examiner? 1 Types 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)	28b. Ti		3☐ DOA Other 28c. Injury a Work?	4 □ Ni		5 🗆 Residenc	e 6 □Other		
To the Hospital or Atlandi within 24 hours after death. To tha Funaral Director; A completely filled in by the ti	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.		m, stre	et, factory, office		28f. L	ocation (Stree lity or Town, S	et and Number State)	or Rural	Route Number,
he Hospi in 24 hour ha Funar pletely fills	edical	29a. Certifier 1 Certifying Ph	ysician: To the best of niner: On the basis of e and manner state	xamination and	death /or inv	occurred at the time estigation, in my opii	, date an nion, dea	d place, and di th occurred at	ue to the caus the time, date	se(s) and manr and place, an	ner as sta d due to	ited. the cause(s)
To the To the Comple	W	29b. Signature and title of certifier	_ n.o. (a	ME)		29c. License				Date signed (
10		30. Name and address of person who	completed cause of dea	ith (Item 23a) (1	Гуре, Г	Print)	Rock	ine, MC	2085	2		
St Regist	ate trar	31. Date filed (Month, Day, Year) APR 05	32. Registrar	s Signature —	1	door	A. A.					

SANKARAN, CHANDRASE HARAN

			1 - State Registrar	State of Maryland / De	partment of Heal	th and Mental I ath	Hygiene 200L	+ 10192
4	Physici /Medic	450	1. Decedent's Name (First, Middle, Last) Norman Collin	is, Jr.		2. Date o	Death Cay Lyan	3. Time of Death UUU5 M
)	Examin		4a. Facility Name (If not institution, give s University of me 5. Social Security Number 6. Sex	7. Age (In yrs. last birthd	ay) If Under 1 Year If U	nwc	4c. County of Dee	rtholece (State or Foreign
\$	Director		212-22-1846 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	M 2□F 79 Yrs		burs Min. July	13, 1924	10d. Inside City Limits
	the Maryla 28a-fehov collised at	ector	MD Carro1		Sykesville	2	10g. Citizen of What C	1 ☐ Yes 2 No
	ns 23a or	Funeral Director	7702 Gaither Road	2. Was Decedent Ever in U.S.	21784	ic Origin? (Specify Yes o	USA	
9036	ours after o rel', or itan	þ	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: WWII	If Yes, specify Cuban, Me	exican, Puerto Rican, etc.) Black, Whi	
21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Heath and Mental Hygiene. Deperment of Heath and Mental Hygiene. By injury or other traumatic event, the Madical Examinar must be notified at ance.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	ocedent's Usual Occupation live kind of work done during e. DO NOT use retired) ner & Operato	,	16b. Kind of Business	
Maryland 2	uld be filed Vental Hygi irked othar itic event.	To Be Co	17. Father's Name (First, Middle, Last) Norman Roland		18. N	Mother's Neme <i>(First, Mic</i> Alverta And	ddle, Maiden Surname)	
e, Mary	and 2 sho fealth and) m 27 ie me her traume		19a. Informant's Name/Relationship (Type Mrs. Maryanna Coll	ins (Wife) 770	ailing Address (Street and N 2 Gaither Roa sposition (Name of		e, MD 21784	
Baltimore,	it. Peges 1 artment of h ortant: if ite njury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	emoval from State White R	ock Cemetery	4/2/04	Sykesville	e, MD
Ba	Depermine Composition of the Com		Blian Z. 23a. Part1. Enter the disease, or compli	cations that caused the death. Do not	AZ Name and Address of A HAIGHT FUNERA Sykesville, enter the mode of dying, suc			Approximate
	nysician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Sepsis Due to (or as a consequence of):				Interval Between Onset and Death
	cate be executed XX bhysician and XX the burial-transit and	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cauco Distance of any that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
P.O. Box 687	Physicien: The law requires that the death certificate trinis certificate has been signed by the attending physical director, page 2 should be detached for use as the trial director.	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of deeth 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	olivery Day Year
rds, P.	w requires that been signed by should be deta	ed by Ph	Part II. Other significant conditions con Respiratory Favour		e underlying cause given in F		oid tobacco use contribute t	o the cause of death?
l Reco	The law re cate has bee page 2 sho	Completed by	Renal Failur			a	erformed? death?	utopsy findings available completion of cause of
Division of Vital Records,	To the Mespital or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	To Be	27. Manner of Death	ospital: 1 Inpatient 2 ER/Outpa 28a. Date of Injury (Month, Day Yeer) Injur	tient 3 DOA Other: 4[nly one) Residence 6 Other (Specified how injury occurred	ecify)
Jivisior	To the Mespital or Attending within 24 hours after death. To tha Funerel Director: After completely filled in by the funer	Certification;	1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 Yes	28f. Locatio	on (Street and Number or R Town, State)	lural Route Number,
	e Hespital 124 hours a R Funerel i letely filled	edical Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Examin	sicien: To the best of my knowledge, d ler: On the basis of examination and/o and manner stated.	eath occurred at the time, da r investigation, in my opinion	ite and place, and due to	the cause(s) and manner a	s stated. e to the cause(s)
)	To th To th	Me	29b. Signature and title of certifier • Glowing & Tan	1	29c. License num		29d. Date signed (Mon. 3 29 2	th, Dey, Year)
	4		30. Name and address of person who co Jennife Ta 31. Date filed (Month, Day, Year)	mpleted cause of death (Item 23a) (Ty 22 5, 61	pe. Print) reene St. Ba	Immore, MD	21201	
	Sta Registi		APR 0 5 2004	German & Signature	In the			

			1 - For State Registrar	State o	of Marylar	id / Depa <i>Cei</i>	artment of F	lealth a Death	and Ment	tal Hyg R	ienez (004	10193
	Dhysisi	200	1. Decedent's Name (First, Middle, L	.ast)						ate of Deat		Year	3. Time of Death
	Physici /Medic		Katherine		Cu	nningh				ril l	, 2004		4:35 PMM
	Examin	er	4a. Facility Name (If not institution, g				4b. City, Town, or		of Death			nty of Death	
			Potomac Valley 5. Social Security Number 6.	Nursing	7. Age (In yrs.	last hirthday)	Rockvil	Le If Under 2	24 Hrs. R D	ate of Birth		ontgo	
	Funeral Director		062-16-2384	1□M 2√F	85	Yrs.	Months Days	Hours	Min. (A	Month, Oay,	Year) , 1918	Cou	place (State or Foreign ntry)
	ס		Usual Residence of Decedent						100	L. 23	, 1910) New	TOPK
	uylan show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	8a-fa	Director	Maryland Montgo	mery	Roc	kville							1 ☐ Yes 2 ☑ No
	with it		10e. Street and Number	11 51			10f. Zip Code			11	0g. Citizen o		ntry?
	eath ms 23	era	1235 Potomac Va		edent Ever in U	.S. 13.V	20850 Was Decedent of H	ispanic Orio	nin? (Specify)	Yes or No-	U.S.	A . ace - Ameri	can Indian
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examinat must be rediffed at	by Funeral	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Fo	orces? 2∐MNo ve		f Yes, specify Cuba 1 ☐ Yes 2 ☐XNo	Specify:	, Puerto Rican	n, etc.)	В	lack, White,	etc.
Š	2 hou	ted	15. Decedent's	Education		16a. Deced	ient's Usual Occup	ation			16b. Kind of	Buşiness/In	dustry
21215-0036	I within 7. liene. r than "n the Medi	Completed	(Specify only highest g	College (Clerk	kind of work done o DO NOT use retired	during most ()	or working]	New Yo Divisi Unemp1	on of	
פַ	e filed al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Lat	st)				18. Mothe	r's Name (Firs				
Maryland	Ments Ments arked atic e	To	John McKinney					Evely	n Seay				
lar	2 sho and Is mu		19a. Informant's Name/Relationship				ng Address (Street a				•		
e o	1 and lealth em 27 ther t		Debra Nichols/Nie	ece	20h F		S. Eads S	t., #	738, A:		ton, V		
Baltimore,	permit. Pages Department of I Importent: If ite any injury or of		1 X Burial 2 ☐ Cremation 3		State Fo	remetery, cren rk Unio	natory or other plac on Baptis	+ 1					
≣	artmer artmer ortent injury		* 4 ☐ Donation 5 ☐ Other (Special Signature Funeral Service Lice		Ch	urch Ce	emetery	! 4	4/6/04 v Bland-	⊩Reid Reid	icking Funer	ham,	VA me
Ba	Depi Impo		Donnin	1/11/1	301.00				11/25				ville, VA
	Ffrysician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on e	caused the deat	h. Do not ent	er the mode of dyin					raim	Approximate Interval Between Onset and Death 2 weeks
	/Medical Examiner		resulting in death) Sequentially list conditions,		(or as a conseq								
	sit ad	iner	if any, leading to immediate cause. Enter Underlying		(or as a conseq	uence of):							
	icate be executed physicien and the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseq	uence of):				· · · · · · · ·			
8760,	be exicient puria			6.	(5. 45 4 55.1554	201100 01,7							
283		edical		d									
.O. Box	at the death certifia by the attending p tached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	1□Live t	tcome of pregna pirth 2 Feta nant at time of d own	Ideath 3	Ectopic pregnancy Other (specify)					ate of deliventh	ery Day Year
<u> </u>	requires that the reen signed by th hould be detache	by Ph	Part II. Other significant conditions	contributing to d	eath but not res	ulting in the ur	nderlying cause give	en in Part I.	2	3e. Did tob	acco use co	ntribute to th	ne cause of death?
rds	w require been sig should b	ed b	Dementia, Hypert	ension						1 🗌 Ye	s 2□No	3 🗆 Prob	ably 4 XUnknown
Division of Vital Records,	has b	Completed		*						4a. Was ar autopsy perform Yes 2	red?	. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
<u> </u>	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place	of Death (Che				
<u>></u>	Physician: r this certific ral director,	10	1 ☐ Yes 2 📉 No			ER/Outpatien		-XT IAOI	rsing Home				y)
Ĕ	ng e	iio	27. Manner of Death 1 X Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time of Injury	Worl			Describe ho	w injury occu	ırred	
<u> </u>	Attending ir death. ector: After by the fune	icat	2 Accident investigati 3 Suicide 6 Could not	be One Diese	of Injuny - At h	ome farm etr	M 1 ☐ ' eet, factory, office	Yes 2□N		ocation (Str	eet and Nun	aher or Rura	I Route Number,
2	Ditte	Certification;	4 ☐ Homicide determine	build	ing, etc. (Specif	y)	eet, factory, office		201. C	ity or Town	, State)	Del OI Mula	i riodie Number,
2/	Ta = 1 = 1	Medical C	29a. Certifier 1 Certifying F (Check only one)	aminer: On the b	best of my kno sis of examina er stated.	wledge, death tion and/or inv	n occurred at the time restigation, in my of	ne, date and pinion, deat	d place, and du h occurred at t	ue to the ca the time, da	use(s) and nate and place	nanner as si	tated. the cause(s)
	To the Hos within 24 ho To the Fun completely f	Me	29b. Signature and title of certifier			1	29c. License	number		29	d. Date sign	ed (Month,	Dey, Year)
ſ			•		MUL					A	pril:	2, 200)4
4			30. Name and address of person wh	o completed cau	e of death (Item	23a) (Type,	Print)						
1			Shahid Shamim, M.				cive, Sil	ver S	pring,	MD 20	902-3	411	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5 2004	32. F	Registrar's Signa		bould						

			1 - For State Registrar	State of Marylar	nd / Depa <i>Cer</i>	rtment of H	lealth a Death		giene 200	4 10191
	Dhyois	2	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day Yea	3. Time of Death
1	Physic /Medi		SELMA	CARI	RAWA	4		APRIL	2 200	
	Examir	ner	4a. Facility Name (If not institution, give	street and number)	^	4b. City, Town, or			4c. County of De	
			2502 GLEN		<i>D</i> .		RKvill	-		Thora
1	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min (Month, Da	v. Year)	irthplace (State or Foreign Country)
1	Director		Usual Residence of Decedent	7 33	113.			June 17	, 1920	MO.
	/land		10a. State 10b. County	10c. Ci	ity, Town or Loc	cation				10d. Inside City Limits
	Mary Frah	ţ	MD BALT	Maile	(PARKUILL	2			1 Tes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	1h wit		2502 GLEN	coe RD		21	234		0.5	A.
	dea	Funerai		12. Was Decedent Ever in L Armed Forces?	J.S. 13. W	/as Decedent of Hi	ispanic Origi	in? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Ar	nerican Indian,
98	or it	F	1 Never Married _2 Marned	1 ☐ Yes 2 ☐ No If Yes, Give		Yes 22 No	Specify:	ruento rican, etc.)	Specify:	nite, etc.
8	within 72 hours after death with the Maryland ane. then "natural", or itema 23e or 28e-f show ite Medical Evaminer must be redified at	d by	3 Widowed 4 Divorced	Year or Dates:			Open,		Specily.	white
5	nat edice	Completed	15. Decedent's Edu (Specify only highest grade		(Give k	ent's Usual Occupa rind of work done o O NOT use retired	during most o	of working	16b. Kind of Busines	s/Industry
12	filed withii Hygiene. ther then int, the M	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	me. D	CLERK	,		PRESS	CORP.
d 2			17. Father's Name (First, Middle, Last)	2/4		CIERT		s Name (First, Middle,		CORT.
an		To Be	EDMOND RO	ellace				a Schmil		
Maryland 21215-0036	SPEE	-	19a. Informant's Name/Relationship (Ty)		19b. Mailing	Address (Street a		or Rural Route Number		Zip Code)
	d 2 tra		Thomas F. CAR	RAWAY		Glenco		Balte. MO		,
Je,	es 1 an of Heal fitem 2 r other		20a. Method of Disposition	20b. F	Place of Dispos			Date	20c. Location - City of	r Town, State
Ĕ	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		alley Ce		15/04	TIMON	ion Ms.
Baltimore,	permit. Pag Department Important: I any injury o		21. Signall re of Funeral Service License				s of Facility	STOLLA FO		
<u>m</u>	89 6 8 9		Jane Th.	Ftells	75	27 hara	iller -	STELLA FO	W 21234	
			23a. Part. Enter the disease, or compli shock, or heart failure. List only on	cations that caused the deal	th. Do not ente	r the mode of dying	g, such as ca	ardiac or respiratory ar	rest,	Approximate Interval Between
*	Physician		Immediate Cause (Final disease or condition	Metastati	CR	enal	can	cer		Onset and Death
\$	/Medical Examiner		resulting in death)	Due to (or as a consec	uence of):	1	1			79000
	LAUIIIIIICI		Sequentially list conditions, b	Obstruct	VC PU	umonas	m d	HSCUSC		
W	ped jist	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence or}: 1					
	al-trar	xan	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	icate be executed physician and s the burial-transit	dicai E	L.		,					
68	ificate g phy as the	edic	W. W. C.		100					1
Вох	death certific e attending p id for use as	2	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. Date of de	alivery
	death e atte	icla	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	that the de ed by the detached	hys	9 Unknown	9□ Unknown						
		by Physician/Me	Part II. Other significant conditions con	tributing to death but not res	uiting in the und	derlying cause give	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?
brd	requires been sign should be	ted						1 🗆 Y	es 2□No 3□F	robably 4 Unknown
Ö	aw s t s t	Completed						24a. Was a autop		utopsy findings available completion of cause of
E =	ate pag	So						perfor	med? death? 2. No 1 ☐ Ye	·
Vita	ding Physician: Th h. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	occital:				Death (Check only or	ne)	
o	Phys this al dir	. To	1 Yes 2 No	ospital: 1 Inpatient 2		3 DOA Other	4 🗀 Nuisi		ence 6 Other (Spe	ecify)
n	ding h. After fune	Fio	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. injury Work'	at ? ′es 2 ⊡No		ow injury occurred	
Division of Vital Records,	or Attending after death. Director: After in by the funer	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	ome farm stree		es 2 100		treet and Number or F	Jural Pouto Number
Ω	D in the	Certification:	4 Homicide determined	building, etc. (Specif	y)	A, lastory, office		City or Tow	n, State)	urai noute ivaliber,
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	wledge, death (occurred at the time	e, date and g	place, and due to the c	ause(s) and manner a	s stated
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	one)	er: On the basis of examina and manner stated.	ition and/or inve	stigation, in my opi	inion, death	occurred at the time, o	late and place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	J.M.)	29c. License			9d. Date signed (Mon	th, Day, Year)
1			> halmans	(16)		0002	374	7	4/2/04	
	16	1	30. Name and address of person who con	mpleted cause of death (Item	n 23a) (Type, Pi	rint)		. D A		n etc.
	10		31. Date filed MODO DA. TO am D. S.	BALTATZ(5 32/Registrar's Signa	MD.	1232 R	1ce fr	s. Reserve	1ems 2	1237
	Sta Registr		APK 0 5 2004	Diversital solgital	Ag .	Soort 1				

State of Maryland / Department of Health and Mental Hygiene 200 μ 10195 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2004 **Physician** March 31, 10:35 PM GEORGE CHARLES CHRISTIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6 Sax 7. Age (In yrs. last birthday) **Funeral** XXM 2 F 76 Director 217~24~2848 19,1927 Sept. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or Iteme 23s or 28s-1 shov other traumatic svent, the Medical Examinar must be routlind at 1 ☐ Yes 2 ☐ No Maryland Baltimore Sparks~ Baltimore County 10e. Street and Number 10g. Citizen of What Country? 22 Ring Flower Path Unit 103 21152 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. nmed Forces? 1 XIYes 2 □ No WW 11 If Yes, Give & Korean Year or Date& Korean 1 ☐ Never Married XX Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lithographer National Can Corp. 12 vrs. permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item Z7 is marked other eny injury or other trauments. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles B. Christie Dorothy Streb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Christie (Wife) 22 Ring Flower Path Unit 103 Sparks, Md. 21152 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 4~3~2004 4 ☐Donation 5 ☐ Other (Specify) Baltimore, Md. ^{22. Name and Address of Facility} Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 21. Signature of Funeral Service Licensee dessahn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician nizo car disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Comma Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown á Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 340 1 🗌 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 X ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Alter 5 Pending investigation 1 Z Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide 24 hours a filled 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/1/04 016189 N. Karlar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N. Charly St #615 KARKAR MO GEORGE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar		epartment of Health and Sertificate of Death	-	ne No. 2001	+ 10196
	Physici /Medi Examir	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give s	Carter	4b. City, Town, or Location of Dea	ACRIC	Day Year 2 200 4c. County of Dea	<u> </u>
	Funeral Director		5. Social Security Number 331-20-8877 1 Usual Residence of Decedent	M 200 7. Age (In yrs last birtho	ay) If Under 1 Year If Under 24 Hr. Months Days Hours Min	8. Date of Birth	9. Bin	thplace (State or Foreign
	ith the Marylar or 28a-f show	Director	10a. State 10b. County NIA	Baltin	10/P	10g.	Citizen of What Co	10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
036	d within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23e or 28e-f show The Medical Exeminar coust be natified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Sovorced		3. Was Decedent of Hispanic Origin? (.ff Yes, specify Cuban, Mexican, Puer 1 Yes 2 PNo Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Bfack, Whit	
121215-0036	d within giene. r then	Completed	15. Decedent's Edu (Specify only highest grade Elementary(Secondary (0-12)	completed) (G	ocedent's Usual Occupation ive kind of work done during most of wo e. DO NOT use retired Amber Maja	orking 16b.	Hotel	Industry
Maryland	d la b	To Be	Charles Frazier 19a. Informant's Name/Relationship (Ty)	pe, Print) 19b. M	Sallie ailing Address (Street and Number or R	Woods		Zip Code)
	Pages 1 and 2 should nent of Health and Men nt: If item 27 is merke iry or other treumatic		Maxine Turner 20a. Method of Disposition 1 Burial 2 Cremation 3 R		aa Vermont Avergrand (Name of prematory of other place)		MD 2.	1229 Town, State
Baltimore,	permit. Page Department Important: If any injury or once.		* 4 □ Donation / 5 □ Other (Specify) 21. Signature of Funeral Service License	ITH. 2	on Cemetery 7- 22. Name and Address of Ficility Land P March EU	270 Fred	nsaawne hilton	Pass
	Physician		23a. Ranti. Enter the disease, or complishook, of heart failure. List only or immediate cause (Final disease or condition	cations that caused the death. Do not e cause on each line.		c or respiratory arrest,	e, mo	Approximate Interval Between Onset and Death
8760,	Medical Examiner bhysician and bhysician and sthe burial transit	al Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): PHEUMO Due to (or as a consequence of): Due to (or as a consequence of):	MIA			s-days
O. BOX 68/	death certif e attending id for use as	Physician/Medical	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2-20 No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deli Month	very Day Year
2	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions con	tributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco		the cause of death?
Vital Records,	The la ate has page 2	e Completed	25. Was case referred to medical			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ N	prior to death?	topsy findings available completion of cause of
on of	Z S	To B	examiner?	ospital: 1 Inpatient 2 ER/Outpa 28a. Date of Injury (Month, Day Year) 28b. Tim Injur	tient 3 DOA Other: 4 Nursing F	ath (Check only one) Home 5 Residence 28d. Describe how in		rify)
Division	ital or Atte ns after de ral Directo led in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Street a City or Town, Sta	ate)	
~	To the Hospital or Attending Phyministry A holys after death. To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin 29b. Signature and tilk of certifier	icien: To the best of my knowledge, de er: On the basis of examination and/or and manner stated.	path occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation in the time, date and place in time, date and place in the time, date and place in time, date and place	urred at the time, date a	and place, and due Date signed (Month	to the cause(s)
	+	1	30. Name and address of person who co				2.500	10
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5 2004	32. Registrar's Signature	books			

			1 - For State Registrar	State of	of Marylai		artment <i>rtificate</i>				lental Hy	gier Reg. N	- / 1111	4 1019
	Dhysiai		1. Decedent's Name (First, Middle	e, Last)							2. Date of De		ay Year	3. Time of Death
	Physici /Medi		Ruth	Plitt		Da	sher				March			11:25P M
Č	Examir		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, To	wn, or	Location of	of Death		4	c. County of Dea	ath
			5555 Friendship				Chevy						Montgom	ery
	Funeral		5. Social Security Number 577-01-9833 A	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 98	. last birthday) Yrs.	If Under 1 Months [Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	ay, Yea	9. Bi	thplace (State or Foreig ountry) shington, D(
	Director		Usual Residence of Decedent		90	115.					Aug 10	, 1	905 Was	inington, Do
	land ow		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
	Man First	ţ	MD Mon	tgomery		Chevy	Chase							1/2 Yes 2 □ No
	h the	irec	10e. Street and Number				10f. Zip C	ode				10g. C	Citizen of What C	ountry?
	h witi	a D	5555 Friendshi	p B1vd. #	436			208	15			U	SA	
	deat	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Deceder	nt of His	spanic Orig	gin? (Sp	ecify Yes or No Rican, etc.)	>-	14. Race - Am	
9	after or to	J.	1 ☐ Never Married 2 ☐ Marr	ied 1 ☐ Yes	2 YN o		1 ☐ Yes 2 ⊡		Specify:	,	1 110011, 010.7		Black, Wh	
5-0036	ural',	d by	3 AWidowed 4 ☐ Divorced	Year or D	Dates:	,							W	hite
7	within 72 hours after death with the Maryland ene. Than "natural", or tlems 23a or 28a-f show he Magical Examiner must be natitied at	Completed	15. Deceden (Specify only higher	t's Education st grade completed)		16a. Dece	dent's Usual (kind of work of DO NOT use	Occupa done di	tion u <i>ring m</i> osi	t of work	ing	16b.	Kind of Business	s/Industry
2	withly ene. than	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	retired				0-	TO Ilomo	
0 0	filled Hygi sther	ပိ	17. Father's Name (First, Middle,			Tionic	emarci		18. Mothe	r's Name	(First, Middle		vn Home en Sumame)	
Maryland 2121	id be ental ked c	To Be	George Plitt						E1i	zabe	th Ste	ide1	1	
چ	shound M	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (S	Street a					or Town, State,	Zip Code)
ž	alth a 27 is		Betty Ann Crova	ato - Dau	ghter	1407	Buena	Vis	ta A	ve.,	McLear	ı, V	A 22101	
altimore,	of Heritem		20a. Method of Disposition	•	I .	Place of Dispo cemetery, crer	sition (Name	of			Date		Location - City or	Town, State
Ĕ	Page nent unt: If ury o		1 ☐ Burial 2 🖾 Cremation `4 ☐ Donatjon 5 ☐ Other (S		State	etropol			1 _	-29-	04	A1e	xandria	• VA
a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In Important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Modical Examiner must be nutified at once.		21. Signature of Funeral Service	Licensee	100	1 1	2. Name and							
<u> </u>	20 E 20		me !	10001	<u>ax</u>	V P	oyston .O. Bo	x 1	nera. 63 Mi	L HOI	ne eburg,	VA_	20118	
			23a. Part1 Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea each line.	th. Do not ent	er the mode o	of dying	, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between
. 4	nysician		Immediate Cause (Final disease or condition	a	112	4UITO	w							Monset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consec									7.4
	LAGIIIIICI	<u>.</u>	Sequentially list conditions,	b. — Dua to	(or as a consec									LAGO
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	d Due to	(or as a corisec	quence or).								
	axecu al-tra	Examiner	that initiated events resulting in death) Last	c Due to	(or as a consec	quence of):								
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the buriat-transit	dicai E		d										
89	ificate g phy as the	edic		U.										A
Вох	death certifica attending ph for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		75-4						23d. Date of de	livery
m.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregi	ointh 2 ☐ Feta nant at time of o		Ectopic pregi Other (speci						Month	Day Year
0.	at the by th stache	hys	9 🗌 Unknown	9Ll Unkn	IOWII									
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o D	w require been sis	ted					_				10	Yes 2	5 m M 3 □ b	robably 4 Unknown
ပ္	has b	Completed									24a. Was autoj	osy	prior to	utopsy findings available completion of cause of
<u> </u>		So									1 Tes	rmed? 2X N	death? o 1 ☐ Yes	2 □ No
<u> </u>	Physician: The this certificate har all director, page	Be	25. Was case referred to medical examiner?	Hospital				-			(Check only o			
<u></u>	<u> </u>	٠ <u>۲</u>	1 ☐ Yes 2 📉 No 27. Manner of Death	1 1		ER/Outpatien 28b. Time of		Intunt	` 4 ☐ Nur		ne 5 🔀 Resi 28d. Describe I		6 □Other (Spe	cify)
0	tending Ph leath. tor: After th the funeral	tion	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	9	of Injury ith, Day Year)	Injury	м	Mork	?` es 2 □ N		Edd. Describe	1011	ary occurred	
Division of Vital Records,		ifica	3 ☐ Suicide 6 ☐ Could I	not be 28e. Place	of Injury - At h	ome, farm, str	eet, factory, o	-51		_				ural Route Number,
á,	al or a	Certification;	4 Homicide	build	ing, etc. (Speci	fy)					City or To	wn, Stai	te)	
4	INTESPITATION AND STATES OF AND STATES OF A PUNCTURE PROPERTY (INTESTITED OF A PUNCTURE OF A PUNCTUR		29a. Certifier 1 Certifyin	g Physicien: To the	best of my kno	owledge, death	occurred at t	the time	e, date and	place, a	and due to the	cause(s) and manner as	s stated.
C	To the Hespital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical one)	Examiner: On the band man	ner stated.	ation and/or in	estigation, in	my opi	nion, deat	h occurr	ed at the time,	date ar	nd place, and due	e to the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certific	7-	//		1 6		number	-1		29d. D	ate signed (Mont	h, Day, Year) (
7			me	2 just	Y		D	5%	745	6		0/0	29/04	
	4		30. Name and address of person					1/00) (1			(T)	-	
	\		Lila McConnel		30 Wisc Registrar's Signa			4	one.	vy C	nase, N	תז		
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5 20	04	ere	P	spark.	2						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** ELEANOR DOSH 3:00 AM MARCH 31 2004 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Bon Secours Hospital Baltimore City 8. Date of Birth (Month, Day, Year) If Under 1 Year It Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔯 F 215-09-2805 91 7, 1912 Director Sept. New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits in than "natural", or Iteme 23s or 28s-f show XXYes 2 No Director Anne Arundel Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Fairfield Drive 21228 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No It Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3XXWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. permit. Peges 1 and 2 should be filed v Department of Health and Mental Hygie. Importent: if Item 27 is marked other til any injury or other traumatic event. III. Once. Agent/Owner Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Joseph Trapnell, Jr. Laura Virginia Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Thornton Hilleary (Son) 101 Fairfield Drive, Catonsville, MD 21228 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 □ Donation 5 □ Other (Specify) St. James Cemetery 4/2/2004 Lothian, MD 21. Signature of Funeral Service bigansee Hardesty Funeral Home, P.A. 12 Ridgley Avenue, Annapolis, MD 21401 23a. Part1. Enter the Jisease, or Amplications that caused the shock, or heart failure. List only one cause on each line. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYOCARDIAL INFARCTION 12 ACUTE HUURS /Medical Due to (or as a consequence of). Examiner ARTERIOSCLERUTIC DIS EASE HEART UNICNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Physician/Medical Examiner law requires that the death certificate be executed burial-transit PNUEMONIA 2+. 24000 DAY Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Pa ASTHAMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed?

1 Yes 2 No Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ö 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Chack only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D 23300 MD. MARCH 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BCN SECURS HUSPITAL. D. PATEL. 2000W, BALTU. ST. SUDIMIZ BALTO, MD. 21213. 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

APR 0 5 2004

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eral ctor		5. Social Security Number 212-24-5820 10		last birthday) Yrs.	If Under 1 Ye Months Da			, Year) 1933	9. Birth	olece (State or F ntry) Ky LAN
in the line		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	by, Town or Lo	MORE		· · · · · · · · · · · · · · · · · · ·		1	10d. Inside City 1 Types 2
De coll	Director	39010 THE ALA	MEDA		10f. Zip Cod	21218		10g. Citizen	of What Cau	ntry?
S S	by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Amped Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗹	No Specify:	(Specify Yes or No erto Rican, etc.)	Spi	Race - Americ Black, White, ecify: BL	ACK
the Medica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decec (Give life. I	dent's Usual Oc kind of work do DO NOT use re	cupation ne during most of w gired)	vorking		STEE	
tic avent, I	To Be Co	17. Father's Name (First, Middle, Last)	Otis Eaton				THA A	Maiden Sur	Vo X	N67
trauma		19a. Informant's Name/Relationship (Ty MANE FATON	pe, Print) WIFE	19b. Mailir	ng Address (Str	ACAMET	A BAC	or, City or To	own, State Zip	Code)
or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b. I	cemetery, crer	osition (Name or matory or other	place)	Date	20c. Locati	ion - City or To	own, State
any injury or pnce.	r	*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	GA	RKISON	HORES		AUCHW C	DWING.	SMILLS	, MARYL
any ir		21. Signature of Forestal Service Liberts	- Drue	4	905 YO	RK ROA	BAUTIN	rope,	MARYL	ANO 21
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cian dical		disease or condition resulting in death)	Due to (or as a consec		nosti	TIE (1	ANCIEN			14148
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as the t	edical		d							
should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of a 9 ☐ Unknown	al death 3 □	∃Ectopic pregna ∃ Other <i>(specif</i> y			23d.	. Date of deliving Month	ery Day Ye
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ineral	lon: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury		njury at Work?	28d. Describe	now injury o	ccurred	
by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str			28f. Location (\$ City or Tov	Street and N vn, State)	umber or Rur	al Route Numbe
=			sician: To the best of my kn ner: On the basis of examin							
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pletely fill	Medical	29b. Signature and title of certifier	and manner stated.			ense number		29d. Date si	igned (Month,	

sici		State Registrar 1. Decedent's Name (First, Middle, I	Last)	Ce	ertificate of	,	2. Date of De		2004	3. Time of Death
edic		Nellie			Ear	/	Month	30	04	1630 P
nin	_	4a. Facility Name (If not institution, g				r Location of Death		_	ounty of Death	i
		Carroll Hospital Co		/In user land historia		inster	8. Date of Birt		rroll	-lace (Ctate or Foreign
		5. Social Security Number 6 215-14-0442 Usuel Residence of Decedent	.Sex 7. Age	(In yrs. last birthday Yrs.	Months Days	Hours Min.	May 5	y, Year)	Md Md	place (State or Foreig intry)
	tor	10a. State Md Carro	511	10c. City, Town or L Keymar	ocation		-			10d. Inside City Limit
	Funeral Director	10e. Street and Number 5800 Middleburg	Road		10f. Zip Code 21757			10g. Citize	en of What Cou SA	intry?
	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent E Armed Forces? 1 Yes 210 No If Yes, Give Year or Dates:	ver in U.S. 13.	. Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 ☐XNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Amer Black, White Specifywhit	, etc.
		15. Decedent's	Education	16a. Dece	edent's Usual Occup	ation	ina	16b. Kind	d of Business/la	ndustry
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	To Be C	17. Father's Name (First, Middle, La George N. Gard	,			18. Mother's Name Mabel Be		Maiden S	Sumame)	
		19a. Informant's Name/Relationship Carla Trump (dau		l l	ling Address <i>(Street</i> Jasontown					p Code)
		20a. Method of Disposition 1 Bunal 2 Cremation 3 4 Donation 5 Other (Spe			position (Name of ematory or other place y Cremati	ce)	Dete)Zį		ation - City or T ${ t Sville},$	
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State of Maryland /	Department	of Health and	Mental Hygiene	2001

	For	State of Maryland / Department of Health and Mental	Hygiene? 101.
-	State Registrar	Certificate of Death	Reg. No.

		1 - For State Registrar			laryland / De <i>C</i>	partment of I ertificate of	Death	ind Mental	Hygier Reg. r		10203
Physic /Medi		1. Decedent's Name Mark Ja		cbes				Mon	of Death th Ch 29	Day 2004	3. Time of Death
Exami		Route 40	and Ma	loney Roac	Ĭ.	4b. City, Town, Elkton			(4c. County of Deeth Cecil	
Funeral Director		5. Social Security Nu 219-02-6 Usuel Residence of	5607	Sex 7. A 1 ☑ M 2 ☐ F	ge (In yrs. last birthda 25 Yrs.	y) If Under 1 Year Months Days	If Under 2 Hours	Min. (Mon	of Birth th, Day, Yea 14, 19	9. Birth Cour 978 Mary	olece (State or Foreign ntry) 'land
Maryland f show	ro	10a. State	10b. County Anne Ar	ındel	10c. City, Town or Jessup	Location				1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the Ma or 28a Lbe notif	Direc	10e. Street and Num		D13		10f. Zip Code	704			Citizen of What Cour	ntry?
ife, Maryland ZIZID-UU30 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	8133 Was 11. Marital Status 1X Never Marrie 3 □ Widowed	nd 2 Married	12. Was Deceden Armed Forces 1 Yes 2X If Yes, Give Year or Dates:	? INo	3. Was Decedent of H If Yes, specify Cub		in? (Specify Yes , Puerto Rican, et		14. Race - Americ Black, White, Specify: whi	etc.
Maryland ZIZIS-UU30 d 2 should be filed within 72 hours alt th and Mantal Hygiene. Zi is marked other than "natural", or traumatic event, the Medical Exam	Completed	(Special	15. Decedent's E fy only highest gr	ducation	16a. De (Gi life	cedent's Usual Occup ve kind of work done DO NOT use retire	pation during most d)	of working		Kind of Business/Inc	
VIATYIAND Z I Z I S 12 should be filed within " 12 and Mental Hygiene, 7 is marked other than " fraumatic event, "In Mac	To Be Co	17. Father's Name (A	First, Middle, Last James Fo			wechanic		's Name (First, M	liddle, Maide	uto Indust	ry
Wich y	ř	19a. Informant's Nai		Type, Print)		iling Address (Street	and Number	r or Rural Route f	lumber, City		Code)
D 0 0 = =		20a. Method of Dispo	osition Cremation 3 [Removal from State	20b. Place of Dis	position (Name of rematory or other pla	ce)	Date 4/05/04	20c.	AD 20794 Location - City or To Lkridge, M	
permit. Pag Department Important: any injury o		21. Signature of Fun				22 Name and Addre	ess of Facility	Funeral	Home.	at Meadowr	ridge MP, Ir 21075
Physician /Medical Examiner		shock, or heart Immediate Cause (F disease or condition resulting in death)	failure. List only Final	a. Mult	d the death. Do not e line.	nter the mode of dyin	ng, such as c	ardiac or respirat	ory arrest,		Approximate Interval Between Onset and Death
flicate be executed g physician and as the burial-transit	edical Examiner	Sequentially list confluence in Judgment and cause. Enter Under Cause (Disease or in that initiated events resulting in death) La		c.	s a consequence of):					II.	
death certif	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?		2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	′			23d. Date of delive Month	ry Day Year
- 68 E	by	Part II. Other signific	cant conditions	ontributing to death l	but not resulting in the	underlying cause giv	en in Part I.			use contribute to th	
The ate h	Completed								Was an autopsy performed? 'es 2 ☐ N	prior to con death?	osy findings available appletion of cause of
Physician: Th this certificate	To Be	25. Was case referred examiner? 1 ▼ Yes 2 □ N		Hospital: 1 Inpati	ent 2 ER/Outpati	ent 3 DOA Oth		of Death (Check of Sing Home 5		6 Other (Specify	(scene)
anding vath. or: After	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigatio 6 Could not be determined	e 28e. Place of In		PM 10	y at k? Yes 2 No	o PO CO	ion (Street at Town, State	ury securred to	ecycle
To the Hospital or Atti within 24 hours after de To the Funeral Direct cumpletely filled in by the	edical	one)	XXMedical Exam	ysician: To the best niner: On the basis of and manner st	of my knowledge, deal of examination and/or ated.	nvestigation, in my o	pinion, death	place, and due to occurred at the t	ime, date ar	nd place, and due to	the cause(s)
To To E	2	29b. Signeture and ti	tle of certifie	ioni.	-Polloh	29c. Licens O.C.N				ate signed (Month, Erch 30, 20	
Sta	te	30. Name and address A+ C 31. Date filed (Month	1A: 7	completed cause of a completed cause of a completed cause of a complete cause of a com	(Sh)	Print) 111 I	Penn S	treet, B	altimo	ore, Maryl	Land 21201

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 10204 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>004</u> Month **Physician** April 1 5:15 A M Robert C. Fan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Deaton Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 187 M 2□ F Vrs Director 215-21-8542 Aug. 29, Maryland 1976 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Owings Mills 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 236 9249 Harvest Rush Court 21117 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: Chinese δ Snecify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Engineering 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fift Department of Health and Mental Hy Important: If tiem Z7 is marked oth any Injury or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Surname) Be Pat Fan Yvanne Ηп ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9249 Harvest Rush Road Owings Mills, MD. Pat Fan /father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 04/04/2004 Pikesville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fulleral Service Licenses Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part I. Erner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ependymoma **Physician** /Medical Du- to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-translt that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hriknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed 312No certificate 20 No 1 Tes director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes this After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 5 Pending 1 Natural within 24 hours after deam.

To the Funeral Director: Aft death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) D 34974 CPMehta NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 South charles street Raitmore, MD 21230 CHARU MEHTA, MD 31. Date filed At D. D. par 2004 32 Registrar's Bignature Registrar

			For State Registrar	State of M	Maryland		rtmen tificate			and M		Reg. No. 2	004	10	205
	Physicia	an	1. Decedent's Name (First, Middle, Las	•							2. Date of Dea	Day	Year	3. Time o	
	/Medic	al	Kati Elizab 4a. Facility Name (If not institution, give		isher		4h City	Town or	Location of		March		004 ty of Death	2:40	A. M
	Examin	er	The Johns Hopkin				, .	Ltimo) Douin			•	e City	7
	Funeral Director		5. Social Security Number 6. Se		Age (In yrs. lasi	t birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Birt (Month, Da NOV • 25	h y, Year) 1989	9. Birtho Coul Mary	place (State ntry) y Land	or Foreign
	ס		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside (City Limits
	Maryla fed at	tor	Maryland Anne Ar	undel	-	Burr									s 2∰No
	or 28a	Directo	10e. Street and Number	and-	, 0201		10f. Zip	Code				10g. Citizen o	What Cou	ntry?	
	th wit	ralD	7565 Old Stage R	oad			_i_	1061				United			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Intropretant: If item 27 is marked other then "neturel", or items 23a or 28a-f show emportant: If item 27 is marked other then "neturel", or items 27 is marked other then "neturel" or netities at a parce.	by Funeral	11. Marital Status 1 ★Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	es? XNo		Vas Deced f Yes, sped 1 ☐ Yes		spanic Ori n, Mexican Specify:		ecify Yes <i>o</i> r No Rican, etc.)	- 14. Ra Ві Ѕрес	ace - Americack, White, ify: W		
2	72 hou	eted	15. Decedent's Ed (Specify only highest gra-		1	16a. Deced	dent's Usua kind of wor DO NOT us	al Occupa rk done d	ation Juring mos	t of worki	ng	16b. Kind of	Business/In	dustry	
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and 2	id be filed ental Hygic ked other ic event, I	To Be Co	17. Father's Name (First, Middle, Last) Richard Fisher						18. Mothe		e (First, Middle,		ame)		
Maryland	nd 2 shoul Ith and Me 27 Is marl r traumati	F	19a. Informant's Name/Relationship (7 Richard Fisher /			19b. Mailir 7565	ng Address 5 Old	(Street a	nd Numbe ge Ro	er or Rura ad	<i>Route Numbe</i> Glen Bu	er, City or Town	n, State, Zip MD 21	, <i>Code)</i> 061	-
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68760,	icate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	as a consequer	nce of):		-							
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			30. Name and address of person who	completed cause	of death (Item 2	3a) (Type,	Print)	24	R	all.		, Kik	· ·	~ E-	7
	CA	at a	31. Date filed (Month, Day, Year)	Y DE Rec	istrar's Signatur	WUI-	att 2	١١.	D	ML	inort	177	> 3	28.	†
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			For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death	Mental Hygier	. 211111. 1112116.
	Physicia	an	1. Decedent's Name (First, Middle, Last	SY SYLVESTER	GREEN	2. Date of Death Month Munch 3	Day Year 1300 M
	/Medic Examin	-965	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deal	h i	Ac. County of Death
	Funeral Director		5. Social Security Number 6. Se 527 · 79 · /24	To Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreign ACUPINA)
	aryland show	10	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	TIMORE		10d. Inside City Limits 1
	vith the M or 28a-f	Directo	MD 10e. Street and Number 31 VIMV C+	DAC	10f. Zip Code 21220	10g. (Citizen of What Country?
	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f show the Medical Exertiner maat be rotilied at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 1 No	Was Decedent of Hispanic Origin? (S If Yes, specify Curan, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
-0036	hours aft	þ	1 Wever Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🖢 No Specify:	16b.	Specify: BLACK Kind of Business/Industry
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	1 and 2 shoul Health and M tem 27 is marl		199 Informant's Name/Relationship (7 CORY E. GREE	ype, Print BROTHER 3	ing Address (Street and Number or R	BATIM	1 110 71770
Baltimore,	Pages 1 a nent of He ant: If item ary or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State 20b. Place of Disponsion Commetery, cre	Matory or other place) 1 (EMETEL) 4	7.04 BA	Location - City or Town, State PCT, MORE, MARY LAND
Balti	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licent	N	2. Name and Address of Facility A	VEHON C.GR	EENE TINEER HIME DE, 40 21212
20	Physician	0 1	shock, or heart failure. List only of Immediate Cause (Final	offications that caused the death. Do not en one cause on each line.		c or respiratory arrest,	Approximate Interval Between
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):			4,000
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	0	٥	30. Name and address of person who	completed cause of death (Item 23a) (Type	18055927	///	mil 7 2008
	6		SALVA de Silvy	Per, 3001 Hospita	1	rly MA	y land
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		4	For	State of Maryland		rtment of He				1 10007
			Registrer 1. Decedent's Name (First, Middle, La	et)	Cer	lilicate of D	ealli	2. Date of Death	g. No. 200	3. Time of Death
	Physicia		Anne Elizabeth					Month April 1,	Day Yea 2004	11:00 p ^M
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	Funeral		5. Social Security Number 6. S			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1ay 2, 1	Year) 9. E	Birthplace (State or Foreign Country)
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	and wo		Usual Residence of Decedent 10a. State 10b. County	10c. City,	, Town or Lo	cation				10d. Inside City Limits
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	th the or 28g	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	·
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	er dez Items Germ	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. \	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto f	city Yes or No- Rican, etc.)	Black, W	merican Indian, 'hite, etc.
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ore,	es 1 a of He fitem r oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Ca	ace of Dispo metery, crer	sition (Name of natory or other place))		20c. Location - City	or Town, State
altimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		' 4 ☐ Donation S ☐ Other (Speci	fy) For		coln Crema	100+9	4/04	Brentwoo	
Balt	ermit. Depart mport ny inj		21. Signature Fundal Service Lice	1/1/1/1/200	$\frac{22}{5}$	Name and Address	of Facility Oute Fune	ral and	Crematio	n Center
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587	ficate phys s the	edical		_ d					1	
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Division	after of Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specify		oot, ractory, office		City or Town		
17	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page		29a. Certifier Certifying P	hysician: To the best of my know	wledge, deat	h occurred at the time	e, date and place, a	and due to the ca	use(s) and manne	r as stated.
	he Ho in 24 I he Fu pletely	edicai	(Check only 2 Medicel Exe	miner: On the basis of examinat and manner stated.	tion and/or in					
	To t To t	Σ	29b. Signature and title of certifier			29c. License		29	od. Date signed (M	Onin, Day, Year)
	0		Mary	MID			>177-		HIMIT	17,0004
	Ö		30. Name and address of person who	completed cause of death (Item ck, 9707 Medica			Rockvill	e. MD	20852	
	St	ate				sport	2	, 1111	-0072	
	Regist		31. Date filed (Month, Day, Year) APR 0 5	2004	/	//				

		•	For State Registrar		State o	f Mary			irtment of H tificate of I			lental Hy	gien Reg. N	一フ日	04	10208
			1. Decedent's Name (First, Mid	dle, Last)	·							2. Date of D Month		ay	Year	3. Time of Death
;	Physicia /Medic		Edna		Gra	У		Gr	iffin		. 1	March 2		2004	1001	12:00 P M
)	Examin		4a. Facility Name (If not instituti						4b. City, Town, or	Location	of Death		4	c. County	of Death	
			St. Thomas M						Hyatts							orge's
	Funeral Director		5. Social Security Number 238-58-5327	6. Sex	M 2□F	7. Age (I	n yrs. last birti 66	hday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bi (Month, D Feb 2,	rth <i>ay, Yea</i> 19	38	Coun	lace (State or Foreign htry) h Carolina
	pu ,		Usual Residence of Decedent 10a. State 10b. Coun	h		10	Dc. City, Town	orlo	cation						11	0d. Inside City Limits
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	28a-f	Director	10e. Street and Number				wasn.	LIIG	10f. Zip Code				10g. C	itizen of W	/hat Coun	itry?
	with Sa or	₫	1383 Bryant	Stre	et N.E	•			20018					USA		,
	death ms 2;	era	11. Marital Status	T	12. Was Dec	edent Eve	er in U.S.	13. V	Vas Decedent of H	ispanic Or	rigin? (Spe	ecify Yes or N		14. Race	- Americ	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination until 64 in Office.	by Funeral	1 ☐ Never Married 2 ☑ Mi 3 ☐ Widowed 4 ☐ Divorce	1	Armed Fo 1 ☐ Yes If Yes, Gir Year or D	2 ∏ No ve X			Yes, specify Cuba ☐ Yes 21 No	In, мехіса Ѕресіfу		Hican, etc.)		Specify:	k, White, o	
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2	be file tal Hy d oth	Be	17. Father's Name (First, Middl							18. Moth	er's Name	e (First, Middle	, Maide	n Sumam	θ)	
<u>₹</u>	should ind Men	To	John Omus Re				1 72					ykins			a 7:	
<u>a</u>	12 sh h and 7 is m traum	2	19a. Informant's Name/Relatio			a h a m .			g Address (Street a							Code)
	1 and Healt em 2		20a. Method of Disposition	TITH	(nu	sband	20b. Place of	Dispos	Bryant S sition (Name of		-	Washi Date		Dn D Location -		wn, State
פֿר	Pages nent of I ant: If its ury or o		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		emoval from	State	cemeter Roc Chi	ky ky	natory`or other place Branch n Cemeter	(e)	4/3/	'04	Κe	enly,	NC.	
altimore,	permit. F Departm Importer any injur		21. Signature of Funeral Service		90	20	GIIU		. Name and Addres	ss of Facil	lity			,,,,	110	
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П			shock, or heart failure. L	or compli st only or	ications that one cause on e	eaused the				g, such as	s cardiac o	or respiratory	arrest,			Approximate Interval Between Onset and Death
7	Physician		Immediaté Cause (Final disease or condition resulting in death)	_ 8		AR			MONA	5 X	AP	YLES 1				
ı	/Medical Examiner		resulting in death)		Due to	(or as a c	onsequence of		AL INF	ADI	DOA	1.				
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Ö,	ficate be executed physician and sthe burial-transit	Exa	resulting in death) Last		Due to	(or as a c	onsequence o	of):								
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ord	w requir been si should l	ted	JEDJ11, 021	PUM	MYEL	1112	,					1 🗆	Yes	2 No	3 Prob	ably 4 Unknown
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>	nysici nis ce direc	To B	examiner? 1 ☐ Yes 2 █ No	F	fospital: 1 🗆	Inpatient	2 ER/Out	tpatien	t 3 DOA Oth	er: 4 N	ursing Ho	me 5□Res	idence	6 □Othe	er (Specify)
0 0	ing Pł	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pen		28a. Date (Mon	of Injury th, Day Y	ear) 28b. T	ime of	28c. Injun Worl	k?		28d. Describe	how inj	ury occurre	be	
sio	Attending ir death. ector: After by the fune	icat	3 ☐ Suicide 6 ☐ Cou		29a Bland	of Injuny	- At home, far	rm etre	M 1 []	Yes 2 □	11/0	28f Location	(Street a	and Numbe	er or Rura	l Route Number,
<u>≥</u>	afor A after I Direct d in by	Certification:	4 ☐ Homicide dete	mined		ing, etc. (, σει	oc, ractory, cirioc			City or To	wn, Sta	te)		
\wedge	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has compietely tilled in by the funeral director, page 2	edical (29a. Certifier (Check only one) Certifier 2 Medic	ying Phys el Exemi	ner: On the b	e best of ro pasis of ex oner stated	amination and	death d/or inv	occurred at the tin restigation, in my o	ne, date a pinion, de	nd place, ath occurr	and due to the red at the time	cause(s) and mar nd place, a	nner as stand due to	ated. the cause(s)
E)	To the within To the comple	Me	29b. Signature and title of certi		rfur	Da	V		29c. License	e number	7			ate signed		Day, Year) DA 2004
	1		30. Name and address of personal DAL		_		th (Item 23a) (Туре,				IVas,	MD.	208-9	B.	,
	Sta	te	31 Date filed (Month, Day, Ye.	37)	<i>y</i> / √/ 0	Registrar's	Signature	, , ,	Sporks							
	Regist		APR 05	2004	De	The same of the sa	1	1	exorns.							

MARION GAMBLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland / Department of Health and Mental Hygiene	21		N	1
0 1111 1 - 1 0 - 14	~ '	•	U	- Lug

10209 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 31, Marion Gamble MARCH 2004 10:50 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1300 EAST LANVALE STREET APT.327 BALTIMORE CITY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2-15-1934 9. Birthplece (State or Foreign Country)
S.C. 7. Age (In yrs. last birthday) Social Security Number 6. Sex 12 M 2 ☐ F **Funeral** 251-54-9805 70 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatht and Mental Hygiene. The marked other than "natural", or items 23e or 28e-f show ant: If item 27 is marked other than "natural", or items 23e or 28e-f show any or other traumatic event, the Micros 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 14 Yes 2 No Baltimore N/A Md Direc 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21213 1300 E. Lanvale Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondary (0-12) Private Home 5th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Sallie Harrison Tom Gamble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3854 Dolfield Avenue Balto, Md 21215 Cousar - Sister Carrie L. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Durial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Pk | 4-5-2004 Arbutus, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H West Sharner STOKES 4300 Wabash Avenue Balto, Md 21215 Part1. Enter the disease, implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclerotic Cardiovascular Disease **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the Jordan Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ner The law requires that the death certificate be executed the attending physicien and ned for use as the burial-transit Exam Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 3 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page certificate 1 Yes Attanding Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6XX ther (Specify) AT SCENE 1 XYes 2 ☐ No 2 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide ō hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainly as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 24 one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E MARCH 31, 2004

State Registrar 31. Date filed (POR

Me 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

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			1 - For State Registrar	State of Ma	ryland /		artment rtificate			and M	ental Hy		200) 4	1021	0
ì	Physici /Medic		Decedent's Name (First, Middle, Last	Dora	Gow	ans					2. Date of De Month 3	eath Da	y Ye 200	ear) 4	3. Time of Deat 6:45 p.	
	Examin		4a. Facility Name (If not institution, give 4012 Buckingham				Ba1	to	Location o				County of Balto	Death		
ļ	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 188-12-7415	ox □ M 2 🛣 7. Age	(In yrs. last t	Yrs.	If Under Months	1 Year Days	If Under a	Min,	8. Date of Bi (Month, D 4-4-	rth ay, Yea <i>r)</i> 1913	9.	Birthpl Count	S.C.	эign
	Maryland -f show	tor	10a. State 10b. County	altimore	10c. City, To Balt:							-		10	ld. Inside City Lin	
	h with the	ai Director	10e. Street and Number 4012 Buckingh	am Road			10f. Zip	Code				10g. Cil	izen of Wha	it Count	ry?	
036	J within 72 hours after death with the Maryland jien. Jen. Jen. Jen. Jen. Jen. Jen. Jen. J	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marned 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E- Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	ver in U.S.		Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or N Rican, etc.)	0-	14. Race - Black, \ Specify B1	White, e	tc.	
9500-91212	within 72 ane. than "nai	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 11th grade	de completed) College (1-4or 5+		(Give life. I	dent's Usua kind of wor DO NOT us	k done d e retired)	ition furing most	of workii	ng		ind of Busin arylan	ess/Ind	ustry	
Maryland 2	id be filed ental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last) Jake Jones						Mary	Luci						
Baltimore, Mar	permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is mareny injury or other traumatones.		Delores Rawlings 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ 4 □ Denation 5 □ Other (Specify 21. Six nature of Funeral Service Lizeh	- Daughte Removal from State)	20b. Place	2020 of Dispo tery, cren Nat M) Fea	ather ne of ther place Lal E	rbed] Park 4	Lane 0 4-2-2	ate 2004 March I	327 20c. Lo Laui	Balto cation - Cit cel, M West	Co y or Tov	Md 212 vn, State	
- Clark	Prysician /Medical Examiner		23a. Part1. Enter the disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	Ca	ed	e the mode	e of dying	, such s	00 Wa cardiac o	r respiratory a	Aver	nue B		Md 21 Approximate Interval Between Onset and Death	215
8/60,	certificate be executed ading physicien and use as the burial-transit	Ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last	e of):												
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ıtal Keco		Completed	Domento	er b	deni	باقر					24a. Was auto perfe 1 \(\text{Yes} \)		prior	to com	sy findings availa pletion of cause (ble
0	ding Phys h. Atter this funeral dir	ation: To Be	27. Manner Leath 1 Latural 5 Pending 2 Accident Investigation			Outpatien Time of Injury		Bc. Injury Work	r: 4 🗆 Nur	rsing Hon	(Check only one 5 Hesi 8d. Describe	dence		Specify)		
Division	vital or Atta	Certification:	3 Suicide 6 Could not be determined	building, etc.	(Specify)						City or To	wn, State)		Route Number,	
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	vsician: To the best of niner: On the basis of e and manner state	examination a	ge, death and/or inv	estigation,	in my op	inion, deat	d place, a	and due to the	date and	and manne I place, and e signed	due to t	he cause(s)	
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	Registr		APR 0 5 2004	Serva	5	1	bork	21								

State Registrar

DHMH 17 Rev 1/2001

🐲 Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F			giene Reg. No 2004	10212
	. 4		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	ith Day Yeer	3. Time of Death
	Physicia /Medic		Kathryn Eliz	abeth Ges	chwilm			April 1	`	6:00P M
j.	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deat	h	4c. County of Dee	th
1			Genesis Eldercare			Brooklyn			Anne Arun	
	Funeral Director		5. Social Security Number 6. Se 19-32-0230	7. Age	(In yrs. last birthday) 73 Yrs.	Months Days	If Under 24 Hrs. Hours Min.		r, Year) Co	thplece (State or Foreign ountry) ryland
	g		Usual Residence of Decedent							10d. Inside City Limits
	how	_	10a. State 10b. County		10c. City, Town or L	ocation				1 Yes 2 No
	Ba-f	5	Maryland Anne Ar	undel	Linthic				10. 00	
	ith th		10e. Street and Number	_		10f. Zip Code			10g. Citizen of What Co United St	
	ath w	<u>a</u>	510 Greenwood Roa		110	21090 Was Decedent of H	liannia Origin? /C	Capathy Vac of No.		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiena. item 27 is marked other than "natural, or itama 23a or 28a-f ehow other traumatic event, the Medical Ever instruments a rollified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:		Was Decedent of P If Yes, specify Cub 1 ☐ Yes 2 ☒ No	an, Mexican, Puer	to Rican, etc.)	Black, Whi	
ò	2 hou	ted	15. Decedent's Ed	ucation		dent's Usual Occup kind of work done		deina	16b. Kind of Business	/Industry
215	within 7. ena. than "n	ple	(Specify only highest gra	College (1-4or 5-	life.	DO NOT use retire	d)	iking		
21	d with	Completed		3	Regi	stered Nu			Health Ca	re
	d be fila antal Hy ced othe c event,	To Be (17. Father's Name (First, Middle, Last) Thomas Warfield E					me <i>(First, Middl</i> e, na Willi	Maiden Sumame) S	
Maryland	d 2 should be filed within " Ith and Mental Hygiena. 27 is marked other than " traumatic event, the Mer	-	19a. Informant's Name/Relationship (18 Ruth G. Isaksson						or, City or Town, State, m, Marylan	
	of Health of Health item 27 i		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other pla	ce) Apri	Pate	20c. Location - City or	Town, State
<u>o</u>	ages ant of t: If i		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Denation 5 ☐ Other (Specific	Removal from State	Metro Cre		200		Catonsvill	e, Maryland
Baltimore,	permit. Pages Department of Minportant: If ite any injury or of once.		21. Signatule of Fune al Service licer		× ₄	2. Name and Addre rkley-Ruc 21 Crain	ldick Fun Highway	eral Hom	e P.A. en Burnie,	21061 Maryland
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not er	ter the mode of dyi	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
1760,	/Medical Examiner Associate and transit trans	ical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o) as a Due to (o) as a	a consequence of): a consequence of): a consequence of):	ion	xcho			J
.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	у		23d. Date of de Month	livery Day Year
<u>a</u>	ires that i signed by I be deta	by	Part II. Other significant conditions of	contributing to death by	ut not resulting in the	underlying cause gi	ven in Part I.		obacco use contribute t res 2 □ No 3 □ P	o the cause of death?
Ö	w requir been s should	etec		3	1			24a. Was	an 24h Were a	utopsy findings available
Division of Vital Records,	The law ate has b	Completed	Dementir	3				autop perfo	prior to death?	completion of cause of
ita	ysician: Th is certificate director, paç	Be (25. Was case referred to medical examiner?					ath Check on c		
>	Physic this ce al dire	10	1 Tes 2 2 No	Hospital: 1 Inpatie		ent 3 DOA	and the same of th		dence 6 Other (Spe	ecity)
0 4	ng Ph	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Ye <i>er)</i> 28b. Time Injury	Wo		28d. Describe I	how injury occurred	
Ö	Attending rideath. ector: Atter by the fure	atic	2 Accident investigatio]Yes 2 □No			
Divis	at or Attendi s after death. If Director: A	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (S	Street and Number or F wn, State)	lural Houte Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical (examination and/or				cause(s) and manner a date and place, and du	
	To the within 2 To the comple	Me	29b. Signature and title of certifier			_	se number		29d. Date signed (Mon	th, Day, Year)
	- > - 0)\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\		MD	l i	22346	2	4/10	4
			30. Name and address of person who	completed cause of d	eath (Item 23a) (Type					21061
			Jude Mune		7845	DAKW	ood Re	oad e	Jen Bur	rie MD
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	rock!				

DHMH 17 Rev 1/2001

Geshwilm, K

			1 - For Stata Registrar AMEND ITEM #195 1. Decedent's Name (First, Middle, Last)	State of Maryla	and / Depa	artment of tificate of	Health ar <i>Death</i>	nd Mental Hy	/giene2 () (04 10213	
	Physici		Decedent's Name (First, Middle, Last) ALLEN			GORDON		2. Date of D Month MARCH		Year 3. Time of Death 5:35 P M	
	/Medic Examin		4a. Facility Name (If not institution, give str CASEY HOUSE	reet and number)	mber) 4b. City, Town, or Location of Death ROCKVILL			Death	4c. County of		
	Funeral Director		5. Social Security Number 212-36-6507 Usual Residence of Decedent	4 200	rs. last birthday) 55 Yrs.	If Under 1 Year Months Days		Min. 8. Date of 8. (Month, D	irth Pay, Year) 1938	9. Birthplace (State or Foreign Country) MD	
	Maryland a-f show ified at	tor	10a. State 10b. County MD MONTGO		City, Town or Lo	cation ER SPRIN	G			10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	th with the 23a or 28s	al Director	10e. Street and Number 14925 HYDRUS ROAD			10f. Zip Code	20906	5	10g. Citizen of W	hat Country? U.S.A.	
036	in 72 hours after death with the Maryland "neturel", or Items 23a or 28a-f show effeal Establing must be political at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cul 1 ☐ Yes 2 ☐ No		n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race Black Specify:	- American Indian, k, White, etc. WHITE	
Maryland 21215-0036	d within jiene. r than "	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Occu kind of work done DO NOT use retin	during most o	of working	16b. Kind of Bus	siness/Industry	
land	buld be filed Mental Hyginarked other arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) JOSEPH		GORDO	ON	18. Mother's	s Name <i>(First, Middle</i> [E	e, Maiden Sumame	PELTZ	
	12 shoth and 7 is m	•	19a. Informant's Name/Relationship (<i>Type</i> BARBARA GORDON / W	IFE	1492	5 HYDRUA	ROAD -	or Rural Route Number SILVER S	PRING, MI	State, Zip Code) D 20906	
Baltimore,	of of or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		sition (Name of natory or other pla ZION CEM		Date 1/2/2004		DALE, MD	
Balt	permit. Pag Department Importent: eny injury o		21. Signature of Funeral Service Literal	<u></u>	8	900 REIS	TERSTO		PIKESVILI	OS., INC. _E, MD 21208	
	Pnysician /Medical Examiner		23a. Part / Enter the disease, of complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)		ASTATIC	LUNG CA		ardiac or respiratory a	arrest,	Approximate Interval Batween Onset and Death 6 MONTHS	
8760,	cate be executed obysician and the burial-transit	fical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a cons							
O. Box 6	The law requires that the death certific tae has been signed by the attending page 2 should be detached for use as:	ysiclan/Med	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of preg 1 □ Live birth 2 □ Fi 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnand Other (specify)	у		23d. Date Mon	of delivery th Day Year
0	quires that on signed b uld be deta	by	Part II. Other significant conditions cont	ributing to death but not i	resulting in the ur	nderlying cause g	ven in Part I.			bute to the cause of death? 3 🏋 Probably 4 □Unknown	
Il Records,		Completed						24a. Was auto perf 1 Yes	opsy pr ormed? de	ere autopsy findings available for to completion of cause of eath?	
Vital	Physicien: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 ☐ Inpatient 2	☐ ER/Outpatien	t 3 DOA		f Death (Check only ing Home 5 ☐ Res		(Specify) HOSPICE	
Division of	ing Affe une	Certification: T	27. Manner of Death 1 X Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year,		M 1	ny at ork?]Yes 2 □ No	0	how injury occurre		
Divi	in Sight		4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)			City or To	iwn, State)	r or Rural Route Number,	
	To the Hospitel or within 24 hours after To the Funerel Dirrompletely filled in I	ledical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							nd due to the cause(s)	
	To with	Σ	29b. Signature and the of certifier	H		D D	se number 8412	218	29d. Date signed 4/1	(Mogth, Day, Year)	
	10		30. Name and address of person who com CHARLES HARRISO			Print) NCASTER	MILL RO	DAD R	OCKVILLE	, MD	
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 5 2004	32. Registrar's Sig		rocks!					

		. For	State of Marylan			nt of Health		•	ygiene		10011
	_	State Registrar		Cei	tifica	te of Dea	th	1 0 Day of 5		2001	
Physicia	ın	1. Decedent's Name (First, Middle, Last)			Gra	Moway		2. Date of I	Day		3. Time of Death
/Medic Examine		4a. Facility Name (If not institution, give s	treet and number)			, Town, or Locati		Marc		County of Dea	
L Adillill		Harbor Hospita	l Center			altimo				NA	
Funeral Director		200 61-3006	7. Age (In yrs.	last birthday) Yrs.	If Und Months		der 24 Hrs. rs Min.	8. Date of E	Birth Day, Year)	9. Bir	thplace (State or Foreign ountry)
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation						10d. Inside City Limits
Mary 9-1 sh	ţo	HARYLAND NA	BAI	timor	.3.						12 Yes 2 □ No
Note after death with the Marylar art, or Items 23a or 28e-f show Examinat must be notified at	Funeral Director	10e. Street and Number 2027 Robb Street	ef			ip Code /2/3			1	izen of What C	ountry?
ems 2	nera		12. Was Decedent Ever in U. Armed Forces?	S. 13.		edent of Hispanic ecify Cuban, Mex	Origin? (Spican, Puerto	pecify Yes or I	No-	14. Race - Am Black, Whi	
be filed within 72 hours after death with the Maryland Hygiene. Hygiene. All Hygiene Frankling I. I. All Hydical Exertinal must be notified.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 [AN o If Yes, Give Year or Dates:		1 🗆 Yes						American
be filed within 72 ho tal Hygiene. d other than "nature.event, the Modical	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	(Give	kind of w	ual Occupation rork done during r use retired)	nost of worl	king	16b. Ki	ind of Business	/Industry
a filed within Hygiene. other than	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	. 1		raker			00	WW HO	me
yidilio 2.12 build be filed with Mental Hygiene, arked other than attic event, tree	BeC	17. Father's Name (First, Middle, Last)				18. Me	other's Nam	ne (First, Midd		Sumame)	
	၉	Leon LEE	21.1	401 14 111	*	Sh	ieley	Jor		- T C4-4-	7-0-41
C, Mal y C		19a. Informant's Name/Relationship (Ty)	pe, Print)		- 4	SS (Street and Nu.	-0	- BOLL	1111		1 21244
Pages 1 and of He out: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)		lace of Disponentery, cremetery, cremetery, cremetery, cremetery, cremetery, cremeters,	natory or	ame of	4/5/	Date	20c. Lo	cation City or	MARY And
initia		21. Signature of Funeral Service License				and Address of Fa	acility	FUNCA			
Depariming of the pariming of		Mangy m. Tes	THE CONTRACTOR OF THE CONTRACT							e MAKY	land 21224
Physician		23a. Part1. Enter the disease, or complishock, or hear failure. List only or immediate Cause (Final	ne cause on each line.			2007	as cardiac	or respiratory	arrest,	***	Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq		YVUL	W NCT	TUERN	and 30	NOMES	Yuk	16 (ears
LXammes	-	Sequentially list conditions,	Due to (or as a conseq	uence of):	ted	Noca	rdic	Sis			Imonth
te be executed ysician and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Preum								Imonth
e be ex/sician a	cai E		Due to (or as a conseq		cast	Infe	ction				1 month
oo			1)							
The Cords, F.O. BOX 00/00, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3[]Ectopic] Other (pregnancy specify)			-	23d. Date of de Month	olivery D ay Year
that the operation of the detac	y Ph	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	nderlying	cause given in Pa	art I.	23a. Di	d tobacco L	use contribute t	o the cause of death?
law requires that as been signed to 2 should be detailed.	ed by	Schrzophre	enia					1 [∃Yes 2	⊠No 3□P	robably 4 Dunknown
ne law re	Completed							pe	topsy rformed?	prior to death?	utopsy findings available completion of cause of
icien: Tr certificate ector, pa	a	25. Was case referred to medical				26 P	lace of Dea	th (Check onl	2 № No	1 🗆 Yes	s 2 No
ysicie	To B	evaminer?	lospital: 1 🔀 Inpatient 2 🗌	ER/Outpatier	nt 3 🗆 [Other				6 □Other (Spe	ecify)
nding Ph th.: After th s funeral		27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f M	28c. Injury at Work? 1 ☐ Yes 2	2 □ No	28d. Describ	e how injur	y occurred	
INVISION OI To Attending Phy after death. Director: After this Jin by the funeral of	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of		reet, facto	ory, office			(Street an Town, State		lural Route Number,
To the Hospitel or Attending Physicien: The law within 24 bours after death. To the Funerel Director. Then this certificate has completely filled in by the funeral director, page 2 secondinately filled in by the funeral director, page 2.	Medical C		sician: To the best of my kno ner: On the basis of examina and manner stated.								
To the within To the Somple	Me	29b. Signature and title of certifier			2	9c. License numb	100		29d. Dai	te signed (Mon	th, Day, Year)
, > 0		ارت م	CC N	1. D.		RES (100		Mar	ch 30,	2004
2		30. Name and address of person who co									
		Tan Min Cher 31. Date filed (Month, Day, Year)	A 3001 Sow	h Han	Love)	- St. 8	altin	nore	CIVI	2122	>
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	6234	S. A. S.						

			1 - For State Registrar	State of Mary	land / Dep		Health and I	Mental Hygi		
	Physici /Medic		1. Decedent's Name (First, Middle, L James Frank H	enry		4 Ch Ton	and applies of David	APPEL 1	Day 2004	3. Time of Death 2 - 20 A M
	Examin	er	4a. Facility Name (If not institution, g.		TAL	GIEN	PSUZN		4c. County of Deal	
	Funeral Director		259-26-5412	Sex 7. Age (In	yrs. last birthday, 19 Yrs.	Months Day:		8. Date of Birth (Month, Day,) Dec • 27,	9. Bir (Co. 1924 G	thplece (State or Foreign buntry) COrgia
	ratylation -f show live at	tor	Usual Residence of Decedent 10a. State MD Anne Ar		c. City, Town or L Janover	ocation				10d. Inside City Limits 1 ☐ Yes 2X No
1	3a or 28a	Funeral Director	10e. Street and Number 7276 Forest Ave	nue		10f. Zip Code 21076			g. Citizen of What Co USA	ountry?
950	permit. Pages 1 and 2 should be liled within 72 hours after beain with the maryaniu Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. En yellow protestration of the them than "natural", or Itama 23a or 28a-f show eny injury or other traumatic event, the Medical Examinal must be notified at angle.	ğ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give	in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (Siban, Mexican, Puerlo Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
	"nature	Completed	15. Decedent's (Specify only highest g	Education	16a. Dece	edent's Usual Occi kind of work don DO NOT use retii	e during most of wor	rking	6b. Kind of Business	/Industry
9500-61212	al Hygiene. I other than "	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)			n - Machir			al Can Co.
Maryland	Wental Hy Irked othe	To Be C	17. Father's Name (First, Middle, Las William G. Henr					ne (First, Middle, Ma 5. Caldwel		
Mar	of 2 sho th and 7 is ma trauma		19a. Informant's Name/Relationship Nellie Henry -				et and Number or Ru Avenue Ha		City or Town, State, 2	Zip Code)
	is 1 and 1 de la		20a. Method of Disposition	2	Ob. Place of Disp cemetery, cre	osition (Name of omatory or other p	ace)		Oc. Location - City or	Town, Stete
Baltimore,	tment ctant: If tant: If		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	city)	Meadowric	dge Mem.	Park 4/0	03/04 E	lkridge, 1	MD
g	Depar Impor eny in		21. Signature of Funeral Service Lic	= 1/=1 = =	Gē	2. Name and Add Ary L. Ka 250 Washi	ufman Fur	eral Home	at Meadow	wridge MP, Inc 21075
	hysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		nsequence of): APT Insequence of): S15	HEART ARTI	FAILU 227 E	SISTAS	<u>.e.</u>	Approximate Interval Between Onset and Death
. Box 687	death certifical e attending phy od for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetel death 3	□Ectopic pregnan	ю		23d. Date of de Month	livery Day Year
<u> </u>	requires that the di een signed by the hould be detached	by	Part II. Other significant conditions	s contributing to death but no	ot resulting in the (underlying cause o		acco use contribute to	the cause of death?	
Hec	The law ate has b page 2 sl	Completed			······································			24a. Was an autopsy perform 1 Yes 2	prior to	utopsy findings available completion of cause of
VITai	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatie	27.004	ther	ath (Check only one) ice 6 □Other (Spe	
ō	fing After	 -	27. Manny of Death 1 latural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Ye	28b. Time o	of 28c. In		28d. Describe how		city)
	- 9 E E	Certification;	3 Suicide 6 Could not determine			treet, factory, offic	е	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical (Physician: To the best of maminer: On the basis of examiner stated.	mination and/or in					
•	To the within To the comple	Me	29b. Signature-and the office lifter	leg	M		nse number 45,45		d. Date signed (Mont	
	je g		30. Name and add ss of person wh	no completed cause of death	(Item 23a) (Type	Print)	Glen	Bushie	e ms	21061
П	St: Regist	ate	31. Date filed (Month, Day Tear)	4 Registrance	Signature	sports				

DHMH 17 Rev 1/2001

James Henry

State of Maryland / Department of Health and Mental Hygiene 2001 1 - For State Registra Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 2004 MATCH 24 /Medical City, Town, or Location of Death 4c. County of Death (If not institution, give street and number) Examiner 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **№** 2 🗆 F 58 212-44-1272 Yrs MD Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 10b. County od other than "natural", or items 23a or 28a-f show event, the Madical Exerciper relatible relation 1∏Yes 2∏No MD N/A Baltimore City Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 500 Fast Clement Street 21230 USA death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. ant: if Item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No white Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 9 N/A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Guy L. Hobbs Gladys V. Shawer 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna S. Hobbs Wife 500 East Clement Street, Baltimore MD 21230 20c Location - City or Town State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 1
Department of F
Important: if ite
any injury or ott Bayview Crematory 1 Burial 2XXCremation 3 Removal from State March 26, 2004 Baltimore MD ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalure of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, In 1501 E. Fort Awe Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy performed? 2□ No 1 ☐ Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ★ ER/Outpatient P 1 Yes 2 No 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospital or At within 24 hours after of To the Funeral Directions 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical completely (Check only 29c. License number 29b. Signature and title of certified who completed cause of death (Item 23a) (Type, Print) KEISCHA BIENN O.U 3001 HANOUER SHICEL South 32, Registrar's Signature 31. Date filed (Month, Day, Year) APR 0 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 200 la Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Charles Randall Hawke March 30, 2004 8:05 pmM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year Months Days 5. Social Security Number 6. Sex If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) **Funeral** Months Hours Min Director 217-32-4617 68 Feb 15, 1936 Washington, DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 📆 🔥 0 MD Howard Laurel Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, It a Medical Examination institution. 27 Frances Street 20723 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Mamed 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: 3 Widowed 4 Worced White Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Grade 9 College (1-4or 5+) Dispatcher Lenny's Towing Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Philip Hawke Hazel Pauline McLaughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Demas 9708 Whiskey Run daughter Laurel, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) West Arundel Crem. 4/5/2004 Odenton, Maryland 21. Signature of Funeral Service Licensee 9000 Donaldson Funeral Home, P.A. 43 M00770 313 Talbott Avenue Laurel, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Cardiomyopathy resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the sequence (Disease or injury that initiated events resulting in death) Last Coronary Artery Disease month 10 day Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) □Yes 2□No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 90 Emphsema 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Nown End Stage Renal disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ TWO 24a. Was an autopsy Periferal Vascular Disease certificate 2 **XXX** 1 ☐ Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 XX patient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XXNo P this in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural 2 Accident death. 1 Tes within 24 hours after deat To the Funerel Director: 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D24283 March 31, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Yusuf, M.D. 13631 Baltimore Avenue Laurel, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 0600 AM asse 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Montgomen Doring 105 If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. (Month, 30 March 1 □ M **X**[X] F Hours 2 n/a Director 26, 2004 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Show rotified at MD Montgomery Gaithersburg Director 28a-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a or 241 Grange Hall Drive 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XXIO Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. event, the Medical Examiner within 72 hours after 1X Never Married 2 ☐ Married altimore, Maryland 21215-0036 ò 1 ☐ Yes 2**X**☐ No If Yes, Give TYear or Dates: Specify: Completed by Specify: white 3 Widowed 4 Divorced nature 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry rthan Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
snt: If Item 27 Is marked other than ury or other traumatic event, Ing M n/a n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Brian Hasselbalch Siriporn Hasselbalch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 241 Grange Hall Drive, Gaithersburg, MD Brian Hasselbalch/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of t-1 Burial 2XXCremation 3 Removal from State Importent: If any injury or once. Fort Lincoln Crematory * 4 □Donation 5 □ Other (Specify) 3/30/04 Brentwood, MD 21. Signature of Funeral Service Licen ... Simple Tribute Funeral and Cremation Center 1040 Rockville Pike Rockville, MD 20852 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner mmas URE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Box 68760, Physician/Medicai mms use as t IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetel death 3 Ectopic pregnancy for in the past 12 months? Month Day 4☐Pregnant at time of death signed by the a 5 Other (specify) P.O. I 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 2 No 1 Yes 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has lirector, page 2 autopsy performad? 1 ☐ Yes 2 ☐ No 1 Yes 2 (2N)0 or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient Medical Certification; To 2 ER/Outpatient 3 DOA funeral dir this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeret Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide the Hounitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) APR 0 5 2004

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ROOC 32 Registrar's Signature

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			_ State	Maryland		partment of H Certificate of L		Mental Hy	giene	2004	10219
			Registrar 1. Decedent's Name (First, Middle, Last)			Ortinouto or a		2. Date of D	eath	1.0	3. Time of Death
Physic /Med			Catherine Norris Hopk	ins				March	26, Day		9:19 A M
Exam			4a. Facility Name (If not institution, give street and number	r)		4b. City, Town, or		ath	4c.	County of Deal	
			Casey House 5. Social Security Number 6. Sex 7. /	lan (In use In	et hirthd	Rockvil	L1e If Under 24 Hr	s. 8. Date of Bi		Montgom	
Funera Directo			5. Social Security Number 6. Sex 1 M 2 ☐ F 7. /	Age (In yrs. Ia: 87	Yrs	Months Days	Hours Mir		av. Year)	16 Nor	hplace (State or Foreign buntry) th Carolina
			Usual Residence of Decedent				<u> </u>	4,000	, -,	10 1101	
arylan show	Ι,	_	10a. State 10b. County	10c. City,							10d. Inside City Limits 1 ☐ Yes 2 🕅 No
the M.	1	Director	Maryland Montgomery 10e. Street and Number	Garr	ett	Park 10f. Zip Code			10c Cit	izen of What Co	
with 1	2		4409 Oxford Street			20896				S.A.	unity !
death	1 6	runeral	11. Marital Status 12. Was Deceder Armed Force:		. 1	I3. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specify Yes or N		14. Race - Ame Black, Whit	
or lite	Ü	7	1 Never Married 2 Married 1 Yes 2]No		1 ☐ Yes 2 ☐XNo	Specify:	into riioani, etc./		Specify:	e, etc.
hours tural',		ed by	3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education	:	16a De	ecedent's Usual Occupa	ation		16h K		hite
n na	100	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40	r 5+\	/G	ive kind of work done of e. DO NOT use retired	during most of w	orking	100.10	ing of business	muustiy
d with giene er tha	1	EO	12	347		Homemaker				Own Hom	e
be file tal Hy d oth	6	D C	17. Father's Name (First, Middle, Last) J. Norris					ame (First, Middle	, Maiden	Sumame)	
y la	F	2	19a, Informant's Name/Relationship (Type, Print)		10h M	ailing Address (Street a		Walston	or City o	s Tour State	Zin Code)
Md 2 s lth an lth an 27 is r			Wallace Bass (Son)			Box 12 Ox					
s 1 ar		-	20a. Method of Disposition	20b. Pla	ce of Di	sposition (Name of crematory or other place	e)	Date		ocation - City or	
mit. Pages partment of portant: If it y injury or o			1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	.0		vn Mem. Par		29/04	Ne	wport N	ews, VA
parifilliors, Intal yiallia Z.I.Z.13-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ita Madical Examinating Logist and	ouce.		21. Signature of Funeral Service Licensee			22. Name and Addres		1 Home			
- 1020	~	-	23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death.	Do not	Peninsula 11144 War	wick Bl	vd., New	port	News,	Approximate
Physician			Immediate Cause (Final					. ,			Interval Between Onset and Death
/Medica	al		regulting in death)	age Ke		Disease					Months
Examine			Sequentially list conditions. b								
bed isi		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	is a conseque	nce of):						
xecut and	3	xan	that initiated events c	is a conseque	nce of):						
icate be executed physician and the burial-transit		edical	d								
rtificat ng phy			IF FEMALE:								
The taw requires that the death certificate be executed. The law requires that the death certificate be executed at has been signed by the attending physician and cage 2 should be detached for use as the buriat-transit	1 40	Pnysician/M	23b. Was decedent pregnant 1 Live birth	2 Fetal d	leath	3 Ectopic pregnancy			:	23d. Date of del	very Day Year
the de		ysic	1 Yes 2 No 4 Pregnant 9 Unknown 9 Unknown	at time of dea	itn	5 Other (specify)					
that hed by deta		Dy Pr	Part II. Other significant conditions contributing to death	but not result	ing in th	e underlying cause give	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
law requires law sould be			Hypothyroidism					1 🗆	Yes 2	No 3□Pr	obably 4 Unknown
as ber	1	Сотріете	Osteoporosis					24a. Was		24b. Were au	topsy findings available completion of cause of
		0	Abdominal Aortic Aneurysm						ormed?	death?	2 🗆 No
VICAL ician: 1 certificat ector, p	d	D D	25. Was case referred to medical examiner?			tiont 3C DOA Othe		eath (Check only			
on or vital net ding Physician: The lav h. After this certificate has funeral director, page 2	- 1	0	27. Manner of Death 28a. Date of Ir	jury 2	R/Outpa 8b. Tim	TIGHT 3 DOA	4 Indiani	Home 5 Res			ity) Hospice
LIVISION OF VITAL I or Attending Physician: after death. Director: After this certification by the funeral director.		ATIOL	1 X Natural 5 ☐ Pending (Month, £ 2 ☐ Accident investigation	Day Year)	Injur		k? Yes 2 □ No				
DIVISIO I or Attendi after death. Director: A		Certification;	3 Suicide 6 Could not be determined 28e. Place of building.	njury - At hom etc. (Specify)	e, farm,	street, factory, office		28f. Location (City or To	Street an wn, State	d Number or Ru	ral Route Number,
Hospital or Pours afte Euneral Dir tely filled in											
To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the		edical	29a. Certifier (Check only one) Certifying Physician: To the beasis and manner	of examination	ledge, de on and/o	eath occurred at the tim r investigation, in my op	ne, date and place pinion, death occ	ce, and due to the curred at the time,	date and	and manner as I place, and due	stated. to the cause(s)
To the within 2 To the complet		Me	29b. Signature and title of certifier	0		29c. License	number		29d. Dat	e signed (Month	n, Day, Year)
0				lex			70		Marc	ch 26, 2	2004
17	And the control of th		30. Name and address of person who completed cause of Eugene P. Libre, MD 10			pe. Print) cticut Ave.	Kanai	natan M	n 209	895	
<u> </u>	State	е	31. Date filed (Month, Day, Year) 32. Regis	trar's Signatu	re			igeon, fi	200		
Regis	stra	r	APR 0 5 2004 Selection	ra /	6	Sparker					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:10 P HARRY W. HARRIS March 24, 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/31/1950 Birthplace (State or Foreign Country)
 WEST VIRGINIA **Funeral** Months Days Hours Min. 236-80-5299 Director 53 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-1 ahow 10d. Inside City Limits the Medical Examiner must be notified at BERKELEY MARTINSBURG 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 25401 USA 261 LABONTE DRIVE death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. titled within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No þ Specify: BLACK 3 Widowed 4 Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

16b. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry VA MEDICAL CENTER than Elementary/Secondary (0-12) College (1-4or 5+) DIETITIAN 12 f Health and Mental Hygie Item 27 Is marked other . c., Marylant.
.c., Marylant.
.cermit. Pages 1 and 2 should be titled.
Department of Health and Menter.
Important: If Item 27 Is reary injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HARRY R. HARRIS GENEVA ROMAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHELLEY M. ALLEN/SISTER 261 LABONTE DR., MARTINSBURG, WV 25401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition MARCH Date 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from State MARTINSBURG, WV MT. HOPE CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 31, 2004 21. Signature of Funeral Service Licenses BROWN PUNERAL HOMEY. _P.O. BOX 821, 327 W. KING ST., MARTINSBURG, W 25402 hallo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 011 cetions Pnysician /Medical resulting in death) Due to (or as a consequence of) **Examiner** ho 5 0 Sequentially list conditions, if any learning lamme date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-transit The law requires that the death certificate be executed He CK Due to (or as a consequence of): Box 68760. physician Physician/Medical (C) 5 use as t attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ŏ Month Day 4 Pregnant at time of death 5 Other (specify) P.O. I ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has breater, page 2 s autopsy perform 1 🗌 Yes 2 🗹 No or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: within 24 hours after death.

To the Funeral Director: Atter this c completely filled in by the funeral dire Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier the and manner stated. 10 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03 127 D0060396 1126 Opal Court Hagerstown 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARID MUR SHED 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 0 5 2004

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene $200\,\mathrm{L}$ Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** John Renton Hunter March 23. 2004 3:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's 4907 St. Barnabas Road Temple Hills If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1⊠M 2□F Yrs. 10/23/1914 Director 89 Scotland 5 4 1 365-05-5860 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show rthan "natural", or Items 23a or 28e-f shov the Medical Examiner (ust be notified at 1 ☐ Yes % ☑ No Maryland Prince George's Temple Hills Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 USA 4907 St. Barnabas Road Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: Specify by 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Clergy Christian Minister permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Importent: if item 27 Is marked othe any injury or other treumatic event, 9068. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Hunter Janet Lockhead 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1100 Savannah St. S.E. Washington, D.C. 20032 Sharon P. Mathieu / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 03/26/2004 Cedar Hill Cemetery Suitland, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature uneral Service Licenses 22. Name and Address of Facility. George P. Kalas Funeral Home P.A. alas 6160 Oxon Hill Road Oxon Hill, Maryland 20745 Part 1. Inter the diseas i, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one chalse on each line. 23a. Part1 Enter the diseas Immediate Cause (Final disease or condition resulting in death) Bilatereral Pneumonia **Physician** /Medical Due to (or as a consequence of) **Examiner** Pneumonia Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed Dementia Due to (or as a consequence of) Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Hloknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 2 Mnknown Parkinson's Disease Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: Cther: 1 🗆 Yes € No 1 Inpatient 2 ER/OutpatienI 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ this 28a. Date of Injury (Month, Day Year) : After this funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Division 1 XX atural 5 Pending ours after death.

nerel Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funerel I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) alder no D39501 03/23/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hugh Holder MD 101 Stonegate Drive Silver Spring, Maryland 20905 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2001 10222 For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:30 PM 30 04 Hollis Rosalee /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore N/A 1229 Popar Grove St. If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1-24-1919 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 □ M 2 🛱 F Virginia 85 216-20-0641 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at XXYes 2□No Director Md. N/ABaltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Herns 23a or 21229USA 4302 Adelle Terrace Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 □ Never Married 2 □ Marned 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black þ Widowed 4 □ Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) than permit. Pages 1 and 2 should be filed who Department of Health and Mental Hygient Importent: if Item 27 is marked other than any injury or other traumeting. Janitorial Service 12 Maintenance Service 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lillie Chappell James Arthur Diggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4302 Adelle Terrace, Apt 201, Balto, Md. 21229 Howard Hollis Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cem 4-5-04 Lansdrowne, Md. 21. Signature of Funeral Service Licenses Estep Brothers Funeral Service, P.A. 1300 Eutaw Place, Baltimore, Md. 21217 Lloyd M. Estep

Lloyd M. Estep

Estep Brothers Funeral S
1300 Eutaw Place, Baltimo

23a. Part! Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mis Usula Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse of) Physician/Medical Examiner burial-transit The law requires that the death certificate be executed nete Due to (or as Box 68760, as the t IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 Yes 1 Yes certificate 2 10 Division of Vital Be 25. Was case referred to medical examiner? director Other: Hospital: ence 6 Other (Specify) 1 ☐ Yes 2 No 4 Nursing Home 2 1 Inpatient 2 ER/Outpatient 3 DOA ihis 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After the Hospital or Attending Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Direct 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and iddress of person who controlled cause of death (Item 23a) (Type, Print) ANTHONY 700 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 5

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** Glenna Lee Isner 12:50P^M March 31, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1208 Broadview Boulevard Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1931 1 □ M 2 1 F Days 72 Maryland 212-28-4662 Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 1 □Yes 2 No Glen Burnie Anne Arundel Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 11 Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural, or itema 23a or 28 any injury or other traumatic event, the Mudical Control of the 18 mudical Control of the 18 mudical Control of the 18 mudical Control Cont 21061 United States 1208 Broadview Boulevard Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2√ No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Jessie Thompson 17. Father's Name (First, Middle, Last) Be Robert Ditty 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 19a. Informant's Name/Relationship (Type, Print) 1112 Lucabaugh Mill Road Westminster, Maryland James L. Isner - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 21060 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State Aprilate2, 2004 Glen Burnie, Maryland ` 4 □ Denation 5 □ Other (Specify) Glen Haven Mem. Park 21. Signature of Fune al Service Licensee 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home P.A.
421 Crain Highway s.e. Glen Burnie, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician RECURRENT LUNG CHUCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last attending physicien end for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Fres 2 No 3 Probably 4 Unknown EREBROUASCULAR Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 🗌 Yes 2 🗆 No 1∐ Yes 2 1 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 2 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 121336 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 802 8 RITCHE HUY. BASHDENH, MB KUITN I RUBIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 0 5 2004 DHMH 17 Rev 1/2001

ORIGINAL

	1	Registrar Decedent's Name (First, Middle, Last	State of Marylan 6 per phy G85	'Cert	iticate of I	Death	2. Date of Dea	th	3. Time of Deat
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lical iner		a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	th	4c. County of De	eath
			ARITAN H	SPITAL	131	ALTIM.	ORE	N,	IR
al er	2	i. Social Security Number 6. Sec. 1 Sual Residence of Decedent	7. Age (In yrs	. last birthday) 3 Yrs.	If Under 1 Year Months Days	Hours Min		(Year)	inthplace (State or For- Country)
	<u> </u>	Oa. State 10b. County	10c. C	ity, Town or Loc	ation				10d. Inside City Lin
ţ	5 /	MARYLAND BAL	TIHORE	X.	JALT.	IMOR	<u> </u>		1 □ Yes 2.⊠
Director	1	Oe. Street and Number	2 CIRCLE		10f. Zip Code	7:0		10g. Citizen of What (Country?
Firers	5 1	11. Marital Status	12. Was Decedent Ever in U		as Decedent of H	ispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - An	merican Indian,
È	2	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cuba □ Yes 2 2√ No	Specify:	rto Rican, etc.)	Specify:	BLACK
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) - b 1	12 +++ GPADE 17. Father's Name (First, Middle, Last)			UME.		me (First, Middle,		1101116
α		THOMAS	1	TAC	KSON	LER	1115	12/11	1A-MS
1	- -	19a. Informant's Name/Relationship (7	ype, Pript)	19b. Mailing	Address (Street	and Number or F	lural Route Numbe	r, City or Town, State	
	_	RYAN TACKS	ON (SON)	_ (341	4 KIM	BLEK	D. Woo	DLAWN	MD. 2/2
1	2	20a. Method of Disposition 1 Surial 2 Cremation 3		Place of Dispos cemetery, crem	ition (Name of atory or other plac		Dat6	20c. Location - City of	or Town, State
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ġ		21. Signature of Funeral Service Licen	1/1, W/	22.	Name and Addre	ss of Facility	UN JR. A	MOREN	Home
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		1	For State Registrar	State of Maryland	d / Depa <i>Cer</i>	rtment of He	ealth and I Death		ene 2004	10225
	Physicia		1. Decedent's Name (First, Middle, Last)	PM O A				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give si	reet and number)		4b. City, Town, or L	ocation of Death		4c. County of Dee	
19	Funeral Director		5. Social Security Number 6. Sex 215-78-1484	07. Age (In yrs. Ia M 2□ F	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bir	thplece (State or Foreign ountry)
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	the Many 28a-f sh	Director	Md. NA	Ba	altimo	10f. Zip Code		100	g. Citizen of What Co	1 No Yes 2 No
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	irs after de il', or Itam zember d	by Fun	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	f Yes, specify Cuban □ Yes 🌠 No	Mexican, Puerl Specify:	o Rican, etc.)	Black, White Specify: Bl.	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is merked other than "natural", or items 23a or 28a-f show aumatic evant, the Modical Examinar must be notified at	Completed by Funeral	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or 5+)	(Give	lent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of wo	rking	Sb. Kind of Business	Vindustry
d 21	i filed wit I Hygiene other th	Be Con	5th grade 17. Father's Name (First, Middle, Last)		Labo		18. Mother's Nar	me (First, Middle, Ma	Varies	
rylan	should be ind Mental s markad c urnatic eve	To B	Elvin 19a, Informant's Name/Relationship (Type	Jones	19b. Mailir	ng Address (Street ar	Glady	'S ural Route Number, (Taylor	Zip Code)
	and ealth m 27		Glayds Jones	Mother	522			B, Baltim		21212
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ∑Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, crer	el Cem.			Dundalk,	
Balti	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service License	i CIVIC)	Name and Address		Balti 1101 E.	more, Md. North Av	21202 e.
	Physician		23a. Par 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	ations that caused the death e cause on each line.	n. Do not ent	er the mode of dying	, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	5				
	ned insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uertce of):					
,092	icate be executed physician and s the burial-transit	cai Exa	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
Box 68	certificate nding phy use as the		IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregna		75			23d. Date of de	olivery
P.O. B	that the death certifica ed by the attending ph detached for use as th	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
	sign sign d be	by	Part II. Other significant conditions con	tributing to death but not resu	alting in the u	nderlying cause give	n in Part I.			to the cause of death?
Vital Records,	o - o	Completed	hepatits of					24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available completion of cause of s
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Othe		ath (Check only one		
Division of		tion: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury Work	-4 C radising i	dome 5 ☐ Residen 28d. Describe how		ecify)
Divisi	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, sti	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	iurai Route Number,
	Hospit 24 hour: Funeral etely fille	ledicai C	29a. Certifier 11 Certifying Physical Check only 2 Medical Examination	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the time vestigation, in my op	e, date and plac- inion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	··		29c. License	number	1	d. Date signed (Mon	.1
,	6.		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type	Print)	2+4			30,2004
_	0		megan Duni	1100m 20	25.	4		Balto	·, MP Z	1201
	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 5 200	132. Registrar's Signa	A A	sports	1			

Eura Knox 04-02217 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

PD .	- 1 /		1 - For Unpend Item#23a Registrar Amend Item#8	,27, Fer ME, 083 & 18	yland/Depa 7,4/23/04ee	artment of F	lealth and M Death	lental Hyg	giene2004	10226
	Physici	an	1. Decedent's Name (First, Middle, L.			,		2. Date of Dea Month		3. Time of Death
	/Medic		EUKH	E.	KNO			March	30, 2004	1149 P M
	Examir	ner	4e. Facility Name (If not institution, gi				or Location of Death		4c. County of Dea	th
	Funeral		Bon Secours Hosp 5. Social Security Number 6.		(In yrs. last birthday)	Baltimo	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplece (State or Foreign
315	Director		460-52-9322	1⊠M 2□ F	7 Yrs.	Months Days	Hours Min.	Sept. 16°, 1	(nYsper) C	XAS
(4.)	pur		Usual Residence of Decedent 10a. State 10b. County	1.	10c. City, Town or Lo	nation				10d. Inside City Limits
	darylar f ehow	ō	MARYLAND N/			MORE	CIT	1		1 XYes 2 No
	28a-	Director	10e, Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	h with		1509 GLEN	JEAGLE	RD.	210	239		U.S.A.	
	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or fleme 23a or 28a-1 ehow that the Medical Examination by modified at	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	rer in U.S. 13.	Was Decedent of H	dispanic Origin? (Spean, Mexican, Puerto	cify Yes or No-	14. Race - Ame Black, Whit	
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give	0 20-10	1 ☐ Yes 2 🗷 No	Specify:	,	Specify: 12	IBOK
8	tural Ex	ed b	15. Decedent's E	Year or Dates:	7- 31-76	dent's Usual Occup	ation		16b. Kind of Business	/Industry
21215-0036	hin 72	Completed	(Specify only highest gi		(Give	kind of work done of DO NOT use retired	duning most of working			
21	be filed withintal Hygiene. d other then	Com	12TH GRADE		LET	TER	CARRIE	ER	0.5. Post	TAL SERVICE
pu		Be	17. Father's Name (First, Middle, Las	1)	KNOX	,	18. Mother's Name	(First, Middle,	Maiden Sumame)	
Maryland	d 2 should be th and Mental 7 ie marked o traumatic eve	2	19a. Informant's Name/Relationship	(Tune Print)			Mozell Knox	/ Route Number	City of Four State	Zin Code)
S	d 2 h a 7 l s		DONNA JOR	(Type, Print) ZDAN (DAUG	HTEX 5021	WOODLAN	IDS GLEN	RD, BA	r, City or Town, State, . LTIMORE, M	D 21209
ē,	s 1 a f Hea item othe		20a. Method of Disposition		20b. Place of Dispo				20c. Location - City or	
Ē	Pages nent of int: If it		1 🗷 Burial 2 □ Cremation 3 [1 4 □ Donation 5 □ Other (Spec	☐Removal from State (ify)	CARRISAL	FOREST	04-0	7-2004 0	WINGS MIC	LS, MARYLAND
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lice	V. W. Dlle	am 5	Name and Address	SS OF Facility	JR. FU	NERAL H MORE, MD	OME 01217
-			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused th	ne death. Do not ent					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Asthma						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
	Laurinier		Sequentially list conditions,	b. Due to (or as a	consequence of):					
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		301130443011303 31).					
o,	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
8760,	sate be shysicia the bu	Physiclan/Medical	•	d						
9	Physicien: The law requires that the death certificate this certificate has been signed by the attending physial director, page 2 should be detached for use as the	Med	IF FEMALE:							
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tin	Fetal death 3	Ectopic pregnancy	,		23d. Date of del Month	ivery Day Year
P.O.	that the de ed by the detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ile ot death 2	Other (specify)				
	s that the	by Pł	Part II. Other significant conditions	contributing to death but i	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
rds	w requires been sign should be							1 □ Ye	es 2 No 3 Pr	obably 4 Unknown
00	law re as be 2 sho	plet						24a. Was a autops	n 24b. Were au	stopsy findings available completion of cause of
æ	The cate has page	Completed) perform	ned? death? 2 □ No 1 X Yes	2□ No
Vita	Physician: T this certificat ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		0.11	26. Place of Death			
Division of Vital Records,	Phys r this ral dir	-: To	1 XYes 2 No 27. Manner of Death	1 Unpatient	2 ER/Outpatien		4 Nursing Hon		ence 6 Other (Spec	cify)
on	ding th. : After s funer	tlon	Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	(ear) Injury	Work	k? Yes 2 □No	00. D0001100 110	w injury occurred	
Visi	or Attending after death. Director: After in by the fune	Certification;	3 Suicide 6 Could not to determined		· At home, farm, str	eet, factory, office	2	8f. Location (St	reet and Number or Ru	ıral Route Number,
Ö	itel or rs afte al Die			banding, oto. ((OPOONY)			City or Towr	, State)	
	To the Hospitel or Al within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ▼ Medical Exa	hysician: To the best of r miner: On the basis of ex and manner stated	xamination and/or inv	occurred at the time restigation, in my of	ne, date and place, a pinion, death occurre	nd due to the ca d at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	. ^		29c. License			9d. Date signed (Montl	
			1 Lorke	au)		0.C.	M.E.	M	arch 31, 20)()4
			30. Name and address of person who	OCKE W	W	111 Penn	Street, B	altimor	e, Maryland	d 21201
	Sta Registr		31. Date filed (Month APR 0 5	2004 32. Registrar's	s Signature	book				

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2004 Month **Physician** 9:00 a April Theresa L. Kowaleski /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Manor Care - Rossville Rosedale Baltimore 8. Date of Birth 12725 1906 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sav **Funeral** 97 1 □ M **20**XF 215 05 1884 Yrs Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event. It a Medical Exam as trinial by notified at once. 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No MD Baltimore Essex Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1000 Franklin Ave. Apt.610 21221 **USA** Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Krul Mary Ann Setera ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2910 Garnet Rd. Parkville, MD. 21234 Derek Propalis Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 15 Burial 2 Cremation 3 Removal from State St. Stanislaus Cemt. 4/3/2004 Baltimore, Md. ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatura of Funeral Service/License Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale, Maryland 21237 231. Fert. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause /Final Myocardial Infarction Physician disease or condition resulting in death) 3 weeks /Medical Coronary Artery Disease 10 years **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Wes decedent pregnant 3 ☐ Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown is been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pneumonia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atrial Fibrillation certificate has autopsy performed? Hypertension 1 Yes 1 Yes 2 No 20XNo or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) completely filled in by the funeral director, examiner Hospital: 1 ☐ Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2010No 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death after death. Injury 1XXIatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I To the Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 2, 2004 H35593 30. Name and address of person who completed cause death (Item 23a) (Type, Print) 1124 Mace Avenue Dr. John Loh Baltimore, MD 21221 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middla, Last) 2. Deta of Death Month **Physician** KCGT/av /Medical 4a Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner toWar Howard 0 1214 COUNT If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) If Undar 1 Yaar 5. Social Sacurity Numbar 6. Sax -7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Euneral** 1□ M 2□ F Davs Months Director 085-18-7017 80 Louisiana Usual Rasidanca of Dacadant Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene.
ntt: if Item 27 is marked other than "natural; or items 23s or 28s-f show 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 ☐ No Funeral Director 28a-1 MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 238 7720 Twin Oaks Way 20723 USA 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decadant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 14 Race - American Indian. Black, White, atc. Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2√1XNo Spacify: Spacify. Completed by White 3 Widowad 4 Divorced Yaar or Datas: 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retirad) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Middle School 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) if Health end Mental Item 27 is marked of John Joseph KEating, Sr. Elisabeth Jonval 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, State, Zip Code) Tara K. Woods 676 D Street niece Pasadena, Maryland 21122 20b. Place of Disposition (Nama of cematery, cramatory or othar placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data Depertment of important: If In any injury or o 1 Xurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4/3/04 4 ☐ Donation 5 ☐ Othar (Specify) Silver Spring, MD 22 Nama and Addrass of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensea / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Entar the disease, ol complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaase or condition resulting in death) Examiner Physician/Medical Examine or Attending Physician: The law requires that the death certificate be executed use es the burlel-transit Sequentially list conditions, if any, laading to immediate causa. Entar Underlying Causa (Disaasa or injury that initiated avants bue to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Dua to (or as a consaquance of): rasulting in daath) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobscco usa contribute to tha causa of death? 2 No 3 Probably 4 Unknown þ 2 cate has been signated by page 2 should b 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? ZLINO 1 ☐ Yes 2 ☐ No After this cartification, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant Other: Certification: To 1 ☐ Yes 2 No ≥ ER/Outpatiant 3 DOA 4 ☐ Nursing Home 5 ☐ Residance 6 ☐ Other (Specify) 27. Mannar of Daath 28a. Date of Injury (Month, Day Yaar) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No investigation aftar deeth. 2 Accidant Director: 6 Could not be datermined 3 ☐ Suicida 28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Spacify) 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, State) 2 4 Homicida within 24 hours a To the Funers! D the Hospitai edlcai 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) of per on who completed causa of daath (Itam 23a) (Type, Print) Kat 10805 32. Ragistrar's Signatura 31. Date filad (Month, Day, Year) State APR 0 5 2004 Registra

			For State Registrar	State of Marylan	-		nt of H te of L			F	Reg. No. (2004	10229
	hysicia /Medic	an	1. Decedent's Name (First, Middle, Last) Anthony J. Kurek							Date of Dea Month Arch 2	Day	.004 Year	3. Time of Death 5:30 p M
	zámin	- 2	4a. Facility Name (If not institution, give so Suburban Hospital	reet and number)		1	, Town, or thesd	Location o	f Death		4c. (County of Dear	
	ineral rector		5. Social Security Number 6. Sex XX	7. Age (In yrs. I	ast birthday) Yrs.		er 1 Year Days	If Under 2 Hours	Min	Date of Birt (Month, Day C • 18,	v Year)	9. Birt	thplace (State or Foreign buntry) ew York
Maryland	f show		Usual Residence of Decedent 10a. State 10b. County MD Montgo		, Town or Lo								10d. Inside City Limits 1
with the	or 28a	Direct	10e. Street and Number		•		ip Code	005			-	en of What Co	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene.	il', or items 23a Cominer must	by Funeral Director	3714 Farragut Ave 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	nue 2. Was Decedent Ever in U. Armed Forces? XIXYes 2 □ No If Yes, Give Year or Dates:	1	Was Decilif Yes, sp	edent of Hi ecify Cuba	895 ispanic Orig n, Mexican Specify:	gin? (Specif , Puerto Ric	fy Yes or No- can, etc.)	- 1	nited S 4 Race - Ame Black, Whit Specify: Wi	erican Indian,
Z1Z15-0036 od within 72 hours afi giene.	han "natura e Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	completed) College (1-4or 5+)	life.	kind of w DO NOT	rork done d use retired	during most	t of working			of Business Private	Industry Business
Maryland 2' nd 2 should be filed very life and Mental Hygie	ked other t Ic event, Ib	To Be Co	17. Father's Name (First, Middle, Last) Anthony Vincent K	urek	raii	110 00	ontra	18. Mothe		First, Middle,	Maiden S	Sumame)	
Mary 12 shou h and M	7 Is mar traumat	-	19a. Informant's Name/Relationship (Typ	e, Print)							-	Town, State,	
Baltimore, I bermit. Pages 1 and Department of Heelti	nt: If Item 2 y or other I	9	Christine F. Kurek 20a. Method of Disposition 1 Burial 2 XX emation 3 Be 4 Donation 5 Other (Specify)	20b. P	lace of Dispo emetery, crer ort Lir	osition (Na matory or	ame of other plac	e)	Dat		20c. Loc	MD 2 cation - City or Brentwo	
Baltir permit. P Departme	Importan any injur once.		21. Signature of Funeral Service License	2mi	S i	2. Name a imple 040 R	and Address	ss of Facility bute 1 ille 1	y Funera Pike F	al and Rockvi		mation MD 20	
/Me Exai	sician edical miner	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Myocard Due to (or as a conseq	ial In uence of): clerot	ıfarc	tion			espiratory ar	rest,		Approximate Interval Between Onset and Death Hours Years
Box 68	attending physician and for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Due to (or as a conseq	incy	□Ectopic	pregnancy specify)				2:	3d. Date of de	livery Day Year
P.O	igned by the be detached	by Phys	9 Unknown Part II. Other significant conditions con	9□ Unknown tributing to death but not res	ulting in the u	ınderlying	cause give	en in Part I.		23e. Did to	obacco us	se contribute to	o the cause of death?
ecords, P	been sig should b	eted t	Left Hip Infect:						-	XXX			robably 4 Unknown utopsy findings available
The T	ate has page 2	Completed	Peripheral Vascu	llar Disease						autop perfo 1 Yes	rmed? 2XXNo	prior to death?	completion of cause of
of Vita Physician:	(0) 200	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 thpatient 2	ER/Outpatier	nt 3 🗆 🗆	OOA Oth			Check only o		Other (Spe	cify)
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3/27/04 1430pm

KUREK, ANTHONY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Io1a 6.35 AM Knight 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pel Hill Center RANDAUSTOWN
If Under 1 Year | If Under 24 Hrs. 8. 1 Mursing-Baltimore 8. Date of Birth
(Month, Bay, Year)
Feb 3, 1913 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2√2F 330-26-6036 91 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28a-f ehow enty injury or other treumettic event, I'm Medical Examinational Reprofited at ORGE. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 21 No MD Sykesville Carroll Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6272 Oakland Mills Road 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Dress Making 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maude Baker George Gallaher 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6272 Oakland Mills Rd., Sykesville, MD 21784 19a. Informant's Name/Relationship (Type, Print) Rev. James Rousey (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Springfield Cemetery 3/31/04 Sykesville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HATCHIT FUNERAL HOME & CHAPEL, PA (Bosykesville, MD 21784 (410)-795-1400 PA (Box 195) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit The law requires that the death cartificate be axecuted resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 25 No 1 Tes 2 No 1 ☐ Yes : Aftar this certifical funeral director, p Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Sering Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending Within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Example 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License numbe 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed lause of death (Item 23a) (Type, Print) 20, 670557 31. Date filed (Month, Day, Year) 32. Megistrar's Signature APR 0 5 2004 Registrar

Physician MARION MAR				1 - For State Registrar	State of Marylar	nd / Departme	ent of Health and I	Mental Hygi	ene 2004	10231
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Of Data Flad (Month Day York) On Officiated Signature &	c c	Ġ			completed cause of death (Ite	om 23a) (Type, Print) S.F. Suut	e 3853 Balt	rmore, 1	MD 2120	+
Registrar	1			24 Data Flad (Month Day Vocal)	20 Maintanda Cina					

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1011 Ronald Ε. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Levindale If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day Year) 936 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1**X** M 2□ F Months 67 Pennsylvania 163-30-6931 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural; or items 23a or 28a-f show ury or other traumatic event. He Maryland Examiner must be mutilified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Pa. York York 1 ☐ Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 17402 200 Aloe Court Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Laborer Molybdenum Co. of York 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hester Miller Curvin Knaub 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Aloe Court York, Pa. 17402 Mary J. Knaub/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page:
Department of
Important: If
any injury or
once. 4-7-04 4 ☐ Donation 5 ☐ Other (Specify) Yorktowne Crematory York, Pa. Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examiner attending physician and for use as the burial-transit -Mronic Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No 2 No Division of Vital Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA To 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) te of Injury (Month, Day Year) 27. Manner of De th 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After 1 Natural Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours at 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certified 123767 hemmen ans 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D Debra westheimer, MD 2434 W. Belvedere Ave. Baltimore, Md. 21212 22. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** BER LEGRAND SR APRIL 2 2004 6:53 AM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIHORE RUXTOR 1ANOR If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months 216-20-762 1**☑** M 2□ F Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health end Mentel hygiene. Important: If Itam 27 is marked other than "natural" ~- '- any lijury or other traumatic event 10a. State 10c. City, Town or Location 10d. Inside City Limits BALTIHORE CIT Yes 2□No **Funeral Director** MARILAND 10e. Street and Number 10g. Citizen of What Country? 14 tus 12. Was Décedent Ever in U,S. Armed Forces? USA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Be Completed by BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ME IM PROVEMENT 6+HGRADE SELF-EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EGRAND JIMMY 19a. Informant's Name (Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SON) ST, APT. 403, BALTO, 140 21230

Date 20c. Location - City or Town, State LEADEN HALL KOBERT LEGRANDJR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Melhod of Disposition METRO CREMATOR V

22. Name and Address of Facility

TO SE H H. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State NY-09-04 BALTIMORE MD 4 ☐ Donation 5 ☐ Other (Specify) BROWN TR. FUNERAL HOME 21. Signature of Funeral Service Licensee N. FULTON AVE. BALTO, MD. 21217 2140 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a rest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Physician · ACUTE CEREBROVASCULAR Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medicai Examiner or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physicien and Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) within 24 hours eftar death.

To the Funeral Diractor: After this certificate has been signed by the a completaly filled in by tha funeral director, page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 □ Unknown SARCO 1,10515 Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? IABETES MELLITUS 24a. Was an autopsy performed? 20 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Denursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Yolo Medical Certification: To 27. Manner of Death 1 A Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON MD ZIZOU H. GHILADI. MD. 7600 31. Date filed (Month, Day, Year) - -32. Registrar's Signature State Registrar APR 0 5 2004

				State of Maryland 1 - State Registrar	/ Depa	rtment of tificate of	Health and Death	Mental Hy	giene 2	001	10234
		Physici		1. Decedent's Name (First, Middle, Last) Margaret Ellen	Li.	llard		2. Date of D April		Year	3. Time of Death 5:15 A. M
		/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of Dea	ath	4c. Coun	ty of Death	1
		Funeral Director		Homewood at Crumland Farms 5. Social Security Number 214-03-3347 Crumland Farms 7. Age (In yrs. las	st birthday) Yrs.	Frede If Under 1 Yea Months Days		s. 8. Date of B	irth Pay, 12916	Frede 9. Birth Con	rick pplace (State or Foreign larryland
20		pug *		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	cation					10d. Inside City Limits
5.15am		Manyla -f aho	tor	Maryland Frederick	$\operatorname{Fr}\epsilon$	ederick					1 ☐ Yes 2X☐ No
si O		death with the Maryland ms 23s or 28s-f show	Funeral Director	10e. Street and Number 5955 Quinn Orchard Road		10f. Zip Code	21704		10g. Citizen o	·S.A.	
0.0	920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 ahow amply injury or other traumatic avent, the Medical Examinet: and but notified at once.	b	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ¾ □ No If Yes, Give Year or Dates:		Vas Decedent of f Yes, specify Cu	Hispanic Origin? ban, Mexican, Pue o Specify:	(Specify Yes or N arto Rican, etc.)	BI	ace - Amer ack, White ify: Whi	
	Maryland 21215-0036	ithin 72 houe. e. en "natura	Be Completed	(Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+)	(Give I life. D		upation e during most of w red)	rorking	16b. Kind of		
O	121	iled wi Hygien ther th	Cor	17. Father's Name (First, Middle, Last)	Bookke	eeper	18. Mother's N	ame (First, Middle			ruction
-	lanc	id be fental h	To Be	Herbert Kessler				rgaret C			
1	Mary	nd 2 shou lith and M 27 is mar r traumat		19a. Informant's Name/Relationship (Type, Print) James Renn Lillard/Son			et and Number or it.				
0.0.0	Baltimore,	Pages 1 a lent of Hes nt: If Item ry or otha		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Pla. 20b. Pla. A Donation 5 Other (Specify)	ce of Dispos netery cren 1 TOII	sition (Name of natory or other pi LVET CELL	etery Ap	ril 5, 2	20c. Location 004 Fr	-city or 1 ederi	Town, State .ck, Marylan
	Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee MOOC)21. 22		ress of Facility and Basf t Church				MD 21701
Lillara		Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a conseque	cler	er the mode of d	ying, such as card	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
aret lur	760,	Examiner	il Exan iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen	ince of).						
ga	387	0 %	dicai	d							
20: marg	.O. Box 68	The law requires that the death certificate be execuate has been signed by the attending physician and page 2 should be detached for use as the buriat-tra	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ₩No 9 □Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea	leath 3 🗌	Ectopic pregnan Other (specify)	ncy			ate of deli nonth	very Day Year
	σ,	w requires that the bean signed by should be detact	ed by Ph	Part II. Other significant conditions contributing to death but not result	ing in the ur	nderlying cause (given in Part I.		tobacco use co		the cause of death?
CALDIUM to physician	Vital Records,	The law requate has been page 2 shoul	Complet	H				24a. Wa autr per 1 ☐ Yes	opsy formed)	prior to death?	topsy findings available completion of cause of 2 No
8	Vita	ician: certific ector,	Be	25. Was case referred to medical examiner? Hospital:			thor	eath (Check only			
3	o	Attending Physician: r death. actor: After this certifica	n: To	27. Manner of Death 28a. Date of Injury 2	R/Outpatien 28b. Time of	1 3 00 A	4 140121116	Home 5 ☐ Res 28d. Describe	a how injury occi		cify)
0	ion	uttending death. ctor: Aft y the fun	atio	1 □Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation (Month, Day Year)	7:50	PM 1	Yes 2 No	Fall			
7-1	Division	_ 0 = _	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury At hom building, etc. (Specify)	e, farm, stre	,	θ	5955 6	(Street and Num own, State)	had	Rd Rd 704
6		Hospi 24 hou Funer tely fill	Medical	29a. Certifier (Check only Check on Chec							
7		To the Hospital or within 24 hours aft To the Funeral Discompletely filled in	Med	one) and manner stated. 29b. Signature and title of certifier		29c. Lice	nse nu <i>m</i> ber		29d. Date sign	ed (Monti	n, Day, Year)
		->-0		· Chraw to		D35	5164		April	1,20	004
-		1		30. Name and address of person who completed cause of death (Item 2	23a) (Type,	Print)	h St. F	-d- \	C 1.0	2:7	8.1
		6	240	31. Date filed (Month, Day, Year) 32. Registrar's Signatu		west /	. Jr. 1	recond	IC,MP	21/	
	6.3	St Regist	ate rar	APR 0.5 2004	100	Kar					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Mend Item 25 per ME, G829, 03/25/04dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death George **Physician** R. 6.15 PM March 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner VORTH ARUNDEL BURNIE ARUNDEL HOSPITAL HUNE GIEN Birthplece (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, MAY 29, 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. 1**X** M 2□ F North Carolina 240-62-3011 61 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other treumatic event, the Mudical Examinar must be notified at 10a. State 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1907 Yorkie Avenue 21122 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1X Yes 2 No 1960-If Yes, Give Year or Dates: 1970 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be fited within 7 h and Mental Hygiene.
7 ie marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Painter Self Employed 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Mann Effie Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tree 1907 Yorkie Avenue Margaret Mann/Wife Pasadena, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 3-22-04 Baltimore, MD • 4 □ Donation 22. Name and Address of Facility Cremation Society of 299 Frederick Road Inomo Service Licences MD Inc. Baltimore, MD Thomas Gregor (21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Clinical brain death immediate **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** amoxic encephalopa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Be Completed by Physician/Medical Examiner hemorrhagic that initiated events resulting in death) Last Due to (or as a consequence ol) Box 68760, egratid (PU) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death Qd. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in CENTERATION 238. Did tobacco use contributions contributions are contributions of the c 5 Other (specify) 4 Pregnant at time of death O. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 □Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Hospitel or Attending 5 Pending investigation after death.

Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Dey, Year) 29c. License number and title of certifier 0-22483 MD March 2001

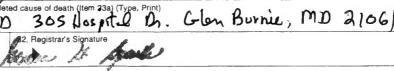
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DHMH 17 Rev 1/2001

State 31 Registrar

31. Date filed (Month, Day, Year)
MAR 2 5 2004

STUDIET JACOBS



			1 - For Amend Item 1 per 1	State o	. Maryla	nd / Depa rdnb <i>Cei</i>	artmen rtificat	t of H e of L	ealth a Death	and M	ental Hy	giene Reg. No.	200	4	1023	36
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	/Medic		4a. Facility Name (If not institution, give	street and nu	mber)		4b. City,	Town, or	Location o	of Death		-	County of De			
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wd.	Funeral		5. Social Se curity Number 6. Se	x		. last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bi	rth	9. E	irthpla	ce (State or Fore	eign
	Director		217-11-2751	Д М 2□ F	36	Yrs.	Months	Days	Hours	Min.	(Month, Di 2-3-6	8	M	Countr Id	y)	
7			Usual Residence of Decedent													
2	how		10a. State 10b. County		10c. C	ity, Town or Lo	cation							100	d. Inside City Lim	
N	- 1	ţ	Md. NA			Baltimo	ore								1 X Yes 2 □	No
ţ	or 28 a na	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What	Countr	y?	
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9	ar Ear	Funeral	11. Marital Status		edent Ever in U	J.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	D-	14. Race - Ar Black, W			
9	P B		1 Never Married 2 Married	1 ☐ Yes If Yes, Gr		i	1 ☐ Yes		Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Specify:			
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IIIG Z I Z I J-0030	her t		8th grade 17. Father's Name (First, Middle, Last)			Labo	orer		10 Matha	de Nome	/Final Adiabati		ps			
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ar y la	i Mer narke	ဥ	Willie		Sydnor	140 11 11		(2)		Bob		-				
	1 40 22 40		19a. Informant's Name/Relationship (T			-					l Route Numb				(ode)	
2 2	tealth m 27		Rochelle McDonald 20a. Method of Disposition	d Si	ster	241 Place of Dispo			ral S		et, Bal				21 <u>213</u>	_
	or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ I		State	cemetery, crer	natory or o	ther place	9)		ale	20C. LO	cation - City	or row	n, State	
	tant: jury		* 4 Donation 5 Other (Specify,		M	t. Carm				4-3-			ndalk,	Md	•	
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P	hysician		Immediate Cause (Final disease or condition	a NECT	intitude in the second	mm D!	MUCI	700	+it	30					Onset and Death	
	/Medical		resulting in death)		(or as a conse		.444		-	·>				1		
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2 4	hysic the b	Physician/Medical		d. ALCO	leon a	BUSE	wi	les_	CHB	ONIC	paux	crea	+646	-		
The law requires that the death cardificate	ing p	Mec	IF FEMALE:				·				\					
	tend or us	an/	23b. Was decedent pregnant in the past 12 months?	1☐Live t	tcome of pregr pirth 2 - Fet	al death 3	Ectopic pr	egnancy				2	3d. Date of o		ay Year	
	he al	sici	1 ☐ Yes 2 ☑No	4□Pregr 9□ Unkn	nant at time of	death 5 ☐	Other (sp	ecify)					MOIIII		ay rear	
	d by t	Phy	9 Unknown													
ה פ	been signed by the attending p should be detached for use as	þ	Part II. Other significant conditions co	ntributing to d	eath but not re	sulting in the ui	nderlying c	ause give	n in Part I.					_	cause of death?	
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מ מ	has be ge 2 sh	Completed									24a. Was		24b. Were	autops	y findings availa	ble
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9	certificate rector, pag	Be	25. Was case referred to medical examiner?		_				26. Place	of Death	(Check only					
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) á	sr death. sector: After this certificate his by the funeral director, page		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of	2	8c. Injury Work			28d. Describe					
5	ath. or: Af	atlo	2 Accident investigation			,.,	М		/es 2 🗆 l	No						
JIVISION OF VICE	er de recto by th	ij Ei	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place	of Injury - At h	nome, farm, str	eet, factory	, office		1	28f. Location (City or To		d Number or	Rural F	Route Number,	
5 }	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;			, (- <i>p</i>	,					,	m, otato,				
J. To the Hospital	hour ly fill		29a. Certifier t Certifying Phy (Check only 2 Madical Exem	sician: To the	best of my kn	owledge, death	occurred	at the tim	e, date an	d place, a	and due to the	cause(s)	and manner	as stat	ed.	
9	in 24 he Fi plete	edical	one)	and man	ner stated.	ation and/or in	restigation	, in my op	inion, deal	in occurr	at the time,	date and	place, and d	ue to ti	ne cause(s)	
Š	To To E	Σ	29b. Signature and title of certifier	^ \ /			290	. License	number	7		29d. Date	signed (Mo	nth, Da	ıy, Year)	
			1/3000	1/	0	Mr		1/	665	3		3	27	12	004	
	2		30. Name and address of person who c		se of death (Ite	m 23a) (Type,	Print)				<u>.</u>	_				
			KICH ARD.KI	trucz,	Univers	ity of M	arylan	1, 22	S. Gre	eene S	St. Balti	imore.	MD 2120	1		
	Sta		31. Date files (Moeth, Day Year)	P.	legistrar's Sign		-		ڼ					-		
	Registr	ar	71.17 0 9.77004	part of	Town Comments	D.	Ann.	150								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth McAllister March Year **Physician** Henry 6:18 AM James 2004 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALtimore VAMEdicAL CENTER NA RALTIMORE Hours Min. 8. Date of Birth (Month. Day, year 11-15-29 If Under 1 Year 9. Birthplece (State or Foreign Country)
S.C. 7. Age (In yrs. lest birthday) **Funeral** Days Months 1⊠M 2□ F Yrs. Director 247-48-3397 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ne 23a or 28a-f sho must be notified at Baltimore 1 No 2 No NA **Funeral Director** Md. 10f. Zip Code 10e. Street end Number 10a, Citizen of Whet Country? USA 21213 2843 E. Federal Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 1 TYes 2 □ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: Be Completed by Black 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domino Sugar Corporatio Laborer 8th grade Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Allen McAllister Henry Louvenia Eagleton 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2407 Kristyn Lane, Ft. Washington, Md. Erna Muhammad 20744 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State TV☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet Cem. 4-6-04 Owings Mills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Sepsis Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed use as the bunal-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the budai-tran Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ Meningitis Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No this cartificata 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 5 Pending investigation Injury 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident I Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) complataly filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. P15834 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 10 N. Gleene Street Boltmore MS 21201 Willy TSai 31. Date filed (Month, Day, Year) 32. Fegistrer's Signature State APR 0 5 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month R 1954 Physician Robert Thomas McDevitt, Jr. /Medical 4b. City, Town, or Location of Death 4c. Sounty of Death 4a. Facility Name (If not institution, give street and number) Examiner Kagi gral ans LAwrel II Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) Funeral Days Hours 12XM 2□ F Maryland 1940 Nov. 22, 63 Director 212-38-2173 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f ehow "natural", or items 23a or 28a-f ehovedical Examiner must be notified at 1 Yes 2 No MD Howard Laurel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20723 USA 9319 Fourth Street Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 7 9 5 0 1959-Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 1965 þ 3 - Widowed 4 - Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hearing & Speech Department of Health and Mental Hygiene Important: If itam 27 is marked other then eny injury or other traumatic event, the Ms 9068. Elementary/Secondary (0-12) College (1-4or 5+) Electronic Technician Testing Equipment 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dorothy Florence Johnson Robert Thomas Joseph McDevitt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9319 Fourth Street, Laurel, MD 20723 Jeanne S. McDevitt/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery Apr. 1, 2004 Crownsville, MD * 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses 313 Talbott Avenue, Laurel, MD 20707 ∕M01103 anielo lions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. 23a. Part1 Enter the disease, or complications shock or leart failure. List only or Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gardiotts what Heat Disease Athenosy **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 nding physician Physician/Medical IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 1 Yes 2 No 20 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ≥ ER/Outpatient 3 DOA nours after death.

naral Director: After this y filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Man of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOS 22. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 5 2004 Registrar

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	s 1 an f Heall Item 2 other		20a. Method of Disposition		20b. Plac		sition (Nam		-		ate	20c. Location			
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic enonge.		21. Signature of Funeral Service	Censee							ral Hom			dge MP,	Inc.
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	urs atter de el', or item	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in C Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:	If Yes, s	edent of Hispanic Origin? (Specify Cuban, Mexican, Puer 25 No Specify:	to Rican, etc.)	Specify.	Rlack
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	hysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		ode of dy ing, such as cardia	c or respiratory a		Approximate Interval Between Onset and Death
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L	A		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	MAC HOSPITA	· BA	TIME	MARTINES
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature Apo	MAC HOSPITA			

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 30° 2004° Masloff Herbert 1:45pm M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Fairhaven Life Care Community Sykesville Carrol1 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Aug 15, 1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 VA **Funeral** 1**⊠**M 2□F 86 Yrs. Director 230-07-6065 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-1 show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Carrol1 Svkesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue 21784 USA death v 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 MYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No δ Specify: 3 ₩Widowed 4 Divorced WWTT White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'ne eny injury or other traumatic event, If a Madie 2008. Wholesale Elementary/Secondary (0-12) College (1-4or 5+) Building Supply Sales Representative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isadore P. Masloff Emma Zabawa (50n)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
534 Sagamore Road Havertown, PA 19083 19a. Informant's Name/Relationship (Type, Print) Mr. H. Spencer Masloff, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 MRemoval from State Mountain View Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 4/3/2004 Danville, VA 21. Signature of Funeral Service Licensee 22 Name and Address of Facility HAIGHT FUNERAL HOME& Sykesville, MD 21784 Buch 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myeloproliferative **Physician** MO /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 2 No Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ Ño ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☑Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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			1 - For State Registrar	State of M	larylan	_	artmen rtificat					Reg. No.	20	04	10	242
	Physici	an	1. Decedent's Name (First, Middle, Las								2. Date of Do Month	Day		ear,	3. Time o	of Death
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	Examin	er	4a. Facility Name (If not institution, give	11.1	tosp	tal			Location	or Death		4C.	County of	Death		
			5. Social Security Number 6. S			last birthday)	If Under	Ltimo 1 Year	If Under	24 Hrs.	8. Date of Bi	rth		9. Birthpl	ace (State	or Foreign
	Funeral Director			□M 21√2 F		O Yrs.	Months	Days	Hours	Min.	(Month, D	ay, Year)	933	Coun MI	try)	,
			Usual Residence of Decedent				1									
	inylan show	_	10a. State 10b. County		10c. Cit	y, Town or L	ocation							10	od. Inside (Sity Limits s 2⊠No
	8a-1 s	Director	Maryland Ceci	.1		Per	ryvil					10. 0				2/2010
	with the	Dire	10e. Street and Number 684 Otsego Street				10f. Zip	2190)3			•	zen <i>o</i> f Wh ited		•	
	eath v	erai	11. Marital Status	12. Was Deceden	t Ever in U	.S. 13.	Was Dece			igin? (Sp	ecify Yes or N		14. Race -			
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene d other than "natural", or tems 23a or 28a-f show event, the Medical Examinat must be notified at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates	? 1952-!	54	If Yes, spec 1 ☐ Yes				ecify Yes or N Rican, etc.)			White,		
Š	2 hou	ted	15. Decedent's E	fucation		16a. Dece	dent's Usua	al Occupa	ation	st of work	ina	16b. Ki	nd of Busi	ness/inc	ustry	
215	within 7 ene. than "n	pie	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of wo)	or work	<i></i> 9					
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p	be fill d oth	Be	17. Father's Name (First, Middle, Last, William Neal							ers Name Kokl	(First, Middle	e, Maiden	Sumame)			
Z a	should be ind Mental marked o umatic eve	2	19a. Informant's Name/Relationship (Tima Print)		10b Maili	ing Address	(Street s			al Route Numb	ner City o	r Town Si	ate Zin	Code)	
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	1 an Heal em 2 ther	1 8	20a. Method of Disposition	10001	20b. F	Place of Disponentery, cre		-			Date		cation - C			
ō	⊕ ○ <u>+</u> <u>+</u>		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		9	emetery, cre :1awn=0				4/2	/04	Saul	t Sta	a Ma	arie,	мт
Baltimore,	artin orts inju		21. Signature of Funeral Service Licer		Joan	_2	2 Name an	d Addres	s of Facil	itv						
B	Depa Impo any i		M. Pgh			72	ESO Wa	Kau Ishir	ıtman ıqton	Fune Blv	eral Ho	me A ridq	t MMI e, Ma	rýla	Inc. and 2	1075
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	ed the deat										Approxima Interval Be	
	Physician	66 1	Immediate Cause (Final disease or condition	Gui	*	n-3	ar	ro	Syn	dx	eme				Onset and	Death
1	/Medical		resulting in death)	Due to (or a	s a conseq	uence of):	4	1 .	1							
н	Examiner		Sequentially list conditions,	b. Dia		20 1	wel	lit	5						gr	2
5	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	He d	s a conseq	10	^ ·								\sim	^
	and and il-tran	хап	that initiated events resulting in death) Last	c. Due to (of a	s a conseq		DION								PV	
8760,	ate be executed obysician and the burial-transit			٠,												
687	ificate g physics the	edic		. u.												
Box	Physicien: The law requires that the death certificate be executed riths certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fete	Ideath 3	⊒Ect <i>o</i> pic pi ⊒ Other (sp					1) 2	23d. Date Monti		ry Day	Year
P.0	that the ed by detacl	Ph	Part II. Other significant conditions	ontributing to death	but not res	sulting in the i	underlying d	ause give	en in Part	l.	23e. Did	tobacco u	se contrib	ute to th	e cause of	death?
Records,	uires tha signed I d be det	d by		J		•	, •				1 🗆	Yes 2	□ No 3	☐ Proba	ably 4.	
Ö	w requir been si should	Completed				-					24a. Wa	s an	24b. We	ere autor	sy findings	s available
Rec	he lav e has	Ę									auto perf	opsy ormed?	pri	or to con ath?	rpletion of	
Vital	dcien: Th certificate rector, pag	0	25. Was case referred to medical						26. Plac	e of Deatl	1 ☐ Yes	2.☑No one)	1	Yes	2 LI NO	
>	ystcie s cert direct	To B	examiner? 1 ☐ Yes 2. No	Hospital: 1 ☑Inpa	tient 2 🗆	ER/Outpatie	nt 3 🗆 DC	OA Othe	0.51		me 5 Res		5 □Other	(Specify)	
o of	ding Physicien: The n		27. Manner of Death	28a. Date of In	jury Jav Year)	28b. Time of	of 2	28c. Injury	at		28d. Døscribe					
<u>io</u>	ath. or: Aft	atio	1 Natural 5 Pending 2 Accident investigatio	n	-, ,	,,	М		Yes 2	No						
Division	r Atte	Certification:	3 Suicide 6 Could not be determined	280. Place of I	njury - At h etc. <i>(Specil</i>		reet, factor	y, office			28f. Location City or To	(Street and wn, State	d Number)	or Rura	Route Nu	mber,
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	To the Hospitel or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune.	Medical		ysician: To the bes niner: On the basis and manner:	of examina											(s)
	o the ithin 2 o the	Med	29b. Signature and title of certifier				290	c. License	number			29d. Dat	e signed (Month, L	Day, Year)	
	ĕ ∓ ĕ ŏ		> chalite	a Min				77.7	49	74		MI	rel	47	oth	n/.
			30. Name and address of person who	completed cause of	death (Iter	n 23a) (Type	, Print)		7 /	- T		1 (0	1.		- 200	04
	10			TA, MI	60	1,50	inth	chi	ule	ost.	reol,	Beet.	time	IVR.	MD 2	21230
	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Sign	ature /			<i>,</i> .							
	Regist	ar	APR 052	UU4 P	- Person	13	de	20ck	2/							

Constance

State of Maryland / Department of Health and Mental Hygiene 2 0 0 La State AMEND Item#26, per VERB, G830, 4/5/04, CC Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 750 AM Month **Physician** 2004 homas 0 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Woodbine

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) 16483 Ed Warfield Rd. Howard Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 88 April 8, 1915 130-10-2084 Director New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r then "natural", or items 23s or 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo New York Queens Woodside 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11377 U.S.A. 30-26 Hobart St. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tyes 2 NoWorld
If Yes, Give
Year or Dates: War II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Philatelist Stamp Dealing and Mental Hygin Is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic aven? 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Milanowicz Joseph Nowaski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30-26 Hobart St., Woodside, NY Steven Nowaski/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Farmingdale, NY Charles Cemetery 3/19/2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, Inc. cale M01296 5130 Wisconsin Ave., NW, Washington, DC 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pheumonia days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Obstructive Pulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Heart Failure Congestive Heart 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home seidence 6 Nother (Specify) 1 Yes 2 No 卢 1 Inpatient 2 EP/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funeral C Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier HO054337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Starting Gute Ct Woodbine Md 21797 Dr. Richard Stefanacci 3250 31. Date filed (Month, D 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month James Physician \mathbf{E}_{\bullet} Posten 03/26/2004 3:35 am /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner Cronwell Nursing Home Towson Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) June 5,1920 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** 1∏ M 2□ F Days Hours Months 137-12-1033 83 Yrs NJ Director Usuel Residence of Decedent it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Haaith and Mantal Hygiene.

whent: If Item 27 is marked other than "natural", or items 23s or 28s-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Medical Examiner must be notified at MD N/A **Baltimore** 1 □Xes 2 □ No Director 10e. Street end Number 28 Brantwood Court 10f. Zip Code 10g. Citizen of What Country? 21236 USA by Funeral 12. Was Decedent Ever in U,S. Armed Forces? \$QTYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stetus Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: white Specify: 31€Widowed 4 □ Divorced Hygiene. other than "natural", Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 US Postal Service Postmaster 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be W Harry Posten Frances Haffer P 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Linda Posten Daughter 28 Brantwood Court, Baltimore MD 21230 other Baltimore, 20b. Place of Disposition (Name of cometery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State Fairview Cemetery March 29, 2004 Middleton NJ 4 ☐ Donation 5 ☐ Other (Specify) parmit.
Dapartm
Importa
any Inju 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificeta be executed ettending physician end I for use es the bunal-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): certificate has been signed by the e irector, page 2 should be detached i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably A Unknown þ 24b. Were autopsy findings available prior to 24a. Was en eutopsy performed? Completed completion of cause of death? Jas 2 K/NU 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 2/ No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the bests of exemination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner steted. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature end title of certifier martha Raymundo D54518 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 5601 Local laurn 31. Dete filed (Month, Day, Yeer) APR 0 5 2004 32. Registrer's Signature State Registrar

			1 - For State Registrar		Marylar			of He	alth and	Mental Hy	giene Reg. No	_		10245
	Physic /Medi		Decedent's Name (First, Middle, Las Grace Powell	t)						2. Date of De April 1		žį Y	ear 3.	7:00pm M
	Examir		4a. Facility Name (If not institution, give 1015 Noyes Drive		9;")		Silver	Spri	ng, MD		40	. County of Manta	Death	
	Funeral Director	ě.	5. Social Security Number 6. Social Security Number 1 368–30–2483 1 Usual Residence of Decedent	_ 37	Age (In yrs. 87	last birthday) Yrs.	If Under 1 Months C		f Under 24 Hrs Hours Min				Birthplace Country)	(State or Foreign
	Maryland a-f show	tor	10a. State 10b. County	tgamery	10c. Cit	ty, Town or Lo		lver	Spring					Inside City Limits
	h with the 23a or 28	al Dire	10e. Street and Number 1015 N. Noyes Dr.				10f. Zip Co	ode	209	910	10g. Ci	izen of Wha	-	
9800	mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland sartment of Health and Mental Hygiene. fortant: If item 27 is marked other than "natural, or Itame 23a or 28a-f show injury or other traumatic event, Ira Medical Exacting rines for redilled at its injury or other traumatic event, Ira Medical Exacting rines for redilled at 18.8.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 ☐ Yes 35 If Yes, Give Year or Date:	is? <mark>X</mark> No		Was Decedent f Yes, specify		anic Origin? (S Mexican, Puel Specify:	Specify Yes or No to Rican, etc.)	D-	14 Race - Black, V	American Ir White, etc. White	
215-(ithin 72 tee. Ian "natu Medics	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4d	or 5+)	(Give	dent's Usual C kind of work o DO NOT use i	done duri	on ing most of wo	rking	16b. K	ind of Busin	ess/Industr	у
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	nd 2 should lith and Men 27 is marke r traumatic		19a. Informant's Name/Relationship (7 Marianne Lamarsh ,			19b. Mailir	_			ural Route Numb			. ,	le)
Baltimore,	Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		te C	Place of Dispo cemetery, cren higan Me	sition (Name natory or othe	of r place)		Date	20c. Lo	ocation - City	y or Town,	State
Balti	permit. Page Department of Important: If sny injury or once.		21. Signature of Funeral Service Licen	Victor P.	Doda,	Tr 22	. Name and A	Address o	of Facility	neral Home timore MD				
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aStroke	sed the deat i line.	h. Do not ent							Ons	proximate erval Between set and Death nonths
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68760,	ate be executed hysician and he burial-transit	ical Examine	that initiated events resulting in death) Last	c	as a conseq	uence of):								years
.O. Box 68	ithat the death certificate be executed ned by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta at time of d	Ideath 3	Ectopic pregr					23d. Date of Month	delivery Day	Year
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f Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2XXIIo		tient 2 🗆	ER/Outpatien	3 □ DOA	Other	 Place of Dea A □ Nursing H 	ath (Check only o		Other (S	Specify)	
	ling After Tune		27. Manner of Death → Natural 2	28a. Date of In (Month, D	ijury Da <i>y Year)</i>	28b. Time of Injury		Injury at Work? 1 🔲 Yes	2 🗆 No	28d. Describe I				
$\overline{\overline{}}$	ital or Attencts after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building,	njury - At ho etc. <i>(Specif</i>)	ome, farm, stre	et, factory, of	fice		28f. Location (S City or Tox	Street and m, State,	d Number or	r Rurai Rou	te Number,
2/	To the Hospital or within 24 hours after To the Funeral Director completely filled in the formula of the formul	edical	29a. Certifier (Check only one) (Check only one) (2 Medical Exami	sician: To the bes ner: On the basis and manner:	or examinat	wledge, death tion and/or inv	occurred at the estigation, in r	ne time, o my opinio	date and place on, death occu	, and due to the orred at the time, o	cause(s) date and	and manner place, and c	r as stated. due to the o	ause(s)
)	To th Within To th	Me	29b. Signature and title of contifier	2		>	1040.01	ense nu			29d. Date	2 04	onth, Day,	Year)
	(0	1	30. Name and address of person who co	empleted cause of	death (Item	23a) (Type, I	Print)	2	7-2	102/	C: -	1	75	267
	Sta Registr	_	31. Date filed (Month, Day, Year) APR 0 5 2004	32 Regis	trar's Signar	ture	Ana 4	1,0	ν'	100, (mare.	Thir	10	· · · · · ·

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Rubv Payne 2004 Jane March 25, 6:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 11629 Lockwood Dr. # 102 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days 1 □ M 2 🕅 F 80 Director 5, 1923 Virginia 226-26-7113 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11629 Lockwood Dr. # 102 20904 Funeral U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Completed by 3 € Widowed 4 Divorced "natural", White th and Mental Hygiene.
7 is marked other than "natur traumatic event, tra Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Bus Driver Montgomery County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Hamsford Fisher Grace Lambert permit. Pages 1 and 2 shoul Department of Health and Mi Important: if item 27 is marl any injury or other traumati once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11629 Lockwood Dr. # 102 Silver Spring, MD 20904 Mindi Knauss (Granddaughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 4/2/04 Serinity Crematory Phoenix, AZ 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Capitol Funeral Service
7211 Lee Highway Falls Church, VA
shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** month /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760. Rars Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 s autopsy performed? res 2.2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 🛣 No ပ 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification; 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 🚰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0

State Registrar

DHMH 17 Rev 1/2001

14201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arms

31. Date filed Month

m.0.

32 Registrar's Signature

D47297

25,2009

PK. Dr. #102 Laurel, MO 20707

			For State Registrar	State of Maryland /		rtment tificate			ind M		Reg. No	004	10247
	Physici	an	1. Decedent's Name (First, Middle, Las							2. Date of Dea	Day	Year	3. Time of Death
	/Media	al	Helen Anne			4b. City, T	Our or	Location	f Dogth	April	1,	2004 ounty of Dec	9:00 p. M
	Examir	er	4a. Facility Name (If not institution, give Manor Care Dulan			-			Deam				ore Co.
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last i	birthday)	If Under 1		If Under 2	24 Hrs.	8. Date of Birt			thplace (State or Foreign ountry)
в	Director		218-12-7946	□M 2XF 80	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da July 25	, 192	23	Maryland
	put A	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation							10d. Inside City Limits
	Manyli f eho	ō		more Co.		Park	/111	0					1 ☐ Yes 2 No
	r 28a-	rect	10e. Street and Number	11101 C 00:		10f. Zip (10g. Citize	n of What C	ountry?
	th with	al D	9404 01d Harf	ord Road				21234	1		Un	ited S	States
	ema er m	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Was Decede f Yes, specif	nt of His y Cubar	spanic Orig	jin? (Spe , Puerto F	cify Yes or No Rican, etc.)	- 14	Black, Wh	erican Indian, te, etc.
36	s afte	y Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1	1	I□Yes 2	No O	Specify:			s	pecity: W	nite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itema 23a or 28a-f ehow int, the Madical Examiner must be mailfied at	Completed by Funeral Director	15. Decedent's Ed	lucation 16	Sa. Deced	lent's Usual	Occupa	tion			16b. Kind	I of Business	/Industry
215	hin 7. Bn 'n	pie	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	life. L	kind of work OO NOT use	retired)	unng most	of workir	ng			County
2	ygien ygien rer th	Con	12 yrs.			Secre						lic So	hools
and	be fill H of oth	To Be	17. Father's Name (First, Middle, Last) Henry Sc	hneider					rs Name rgin	(First, Middle,		u <i>mame)</i> Requar	d
Maryland	should nd Mei mark matic	7	19a, Informant's Name/Relationship (1		9b. Mailin	a Address (Street a			l Route Numbe			
	nd 2 salth ar 27 ls r frau		Mr. John D. Patzs			4 01d						e, MD	21234
ore,	of Hez		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. Place ceme	of Dispos	sition (Name	of or place)	D	ate	20c. Loca	tion - City o	Town, State
ij	Page ment ant: It ury o		'4 □Donation 5 □ Other (Specify	Parky	poor	Cemet	ery	A	pril	5, 200	4 Ba	lltimo	re, Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Meirlal Hygiene. Department of Health and Meirlal Hygiene Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen	Michael E. Canap	P	Name and Leona			W 5	440			d Road MD 21214
	Physician /Medical		23a. Pert1. Enter the disease, or composition shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Done cause on each line. a. Due to (or as a consequence)	ev	er the mode	of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
68760,	that the death certificate be executed to be by the attending physician and detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence.)	se of).								
P.O. Box 6	the death certifica y the attending ph ached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pre Other (spe					23	d. Date of de Month	vilivery Day Year
	sign Ped b	ed by PI	Part II. Other significant conditions of	ontributing to death but not resulting	g in the ur	nderlying ca	use give	n in Part I.		23e. Did to			o the cause of death?
æ	The law ate has t page 2 s	Complet								24a. Was autop perfo 1 Yes	rmed?	24b. Were a prior to death?	utopsy findings available completion of cause of s 2 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	- 1/		(Check only o			
of	> 50	<u>۲</u>	1 Yes 2 No 27. Magner of Death	1 Inpatient 2 EHV	Outpatien Time of		\	4 Nu		ne 5 🗌 Resid			ecify)
on	ding I h. After funer	tion	t Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	м	c. Injury Work 1 Y	? ′ens 2.∐.h				30041104	
Division of	l or Attending after death. Director: After	ertifica	3 Suicide 6 Could not be determined						2	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Certification:	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	ysician: To the best of my knowled niner: On the basis of examination and manner stated.	dge, death and/or inv	occurred a	t the tim	e, date and inion, deat	d place, a	and due to the	cause(s) and p	nd manner a lace, and du	s stated. e to the cause(s)
	To the Within To the comple	Me	29b. Signature and title of certifier			29c.	License	number			29d. Date	signed (Mon	th, Day, Year)
	2		> munta houn	undo mo			054	578			4/21	104	
	13		30. Name and address of person who	completed cause of death (Item 23a	а) (Турө,			,					
			MANTA SAUMUNDO	9601 Wich lau	MB	wy 1	alt	me.	MD	21739			
	Sta Regist		31. Date filed (Month, Day, Year) APR 0 5 2004	32. Registrar's Signature	do	nder							

DHMH 17 Rev 1/2001

		1 - State Registrar	State of Marylan	•	artment of H			jiene leg. No.	2004	10268	
Physic		1. Decedent's Name (First, Middle, Last) William G. Rabe	er Sr.				2. Date of Dea Month		Year 2004	3. Time of Death 1:00a	
/Medi Exami		4a. Facility Name (If not institution, give s 3271 Sykesville Ro	ad		4b. City, Town, or Westminst	er		4c. C	ounty of Death		
Funeral Director		5. Social Security Number 6. Sex 129-10-0094	7. Age (In yrs. 98	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day June 17	Year) 1905	Count	lace (State or Foreign try)	
e Maryland ta-f show lifted at	ctor	10a. State 10b. County Md Carrol1		y, Town or Lo					10	0d. Inside City Limits 1 ☐ Yes 2 ☐No	
th with th 23a or 28 ust be no	Funeral Director	10e. Street and Number 3271 Sykesville Ro	ad		10f. Zip Code 21157		1	USA	en of What Coun	try?	
ire, Maryland Z IZ IS-UUSO s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminar must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ã Year or Dates: 		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2∏ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)		Race - America Black, White, a Specify: white	etc.	
Mithin 72 ho ane. Then "nature then "nature to Medical I	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa kind of work done d DO NOT use retired, lker	uring most of work	king		of Business/Ind	lustry	
Baltimore, Maryland 21215-UU36 bernit. Pages I and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or myortant: if item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exempages.	To Be Co	17. Father's Name (First, Middle, Last) Peter William Rab	er	Dan		18. Mother's Nam Anna Mar			umame)		
ore, Maryla es 1 and 2 should of Health and Men fitam 27 is marke rother traumatic.		19a. Informant's Name/Relationship (Typ. Laurence B. Raber	(son)	3271	ng Address (Street a Sykesvill sition (Name of	e Rd.,We	stminste	r. M			
t. Page trment or trant: If	The state of the s	20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State A1	emetery, crer 1 Coun	natory`or other place ty Cremat	ion 4 - 5-	04	Syke	sville,	Md	
Dermi Depa Impo		Pargranded 1	Spribert	Р	.O. Box 1	95 Sykes	ville, M	10.21	Home & (784	Chape1 Approximate	
Pnysician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Due to (or as a conseq	2	or the mode of dying	g, sacir as cardiac	or respiratory arr	631 ,		Interval Between Onset and Death	
the death certificate be executed to the attending physician and treed for use as the burial-transit of	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of highly that initiated events resulting in death) Last	Due to (or as a conseq								
death certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnating the control of t	ideath 3	Ectopic pregnancy Other (specify)			23	d. Date of deliver Month I	ry Day Year	
hat had be deta	by	10 0 0								o use contribute to the cause of death? 2 No 3 Probably 4 Unknown	
	Completed		0				24a. Was a autops perform	sy	24b. Were autop prior to com death? 1 ☐ Yes	osy findings available inpletion of cause of	
1 OT VICAL P 19 Physician: The ter this certificate neral director, pag	n: To Be	25. Was case referred to medical examiner? 1 □ Yes 250 No 27. Manner of Death 1 ☑ Natural 5 □ Pending	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	h (Check only one) me 5 ≰Residence 6 □ Other (Specify) 28d. Describe how injury occurred)				
UNISION OT Il or Attending Phy after death. Director: After this d in by the funeral d	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str		′es 2 □ No	28f. Location (Si City or Town	Street and Number or Rural Route Number, wn, State)			
To the Hospital or At within 24 hours after C To the Funaral Direct completely filled in by	edical Ce	29a. Certifier 12 Certifying Phys (Check only one) 1 Medical Examin	sician: To the best of my known on the basis of examination and manner stated.	owledge ceatl	n occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the cored at the time, d	ause(s) ar ate and p	nd manner as sta lace, and due to	ated. the cause(s)	
To th To th	Me	29b. Signature and title of certifier	MI		29c. License	number UCG	2	9d. Date	signed (Month, E	Day, Year)	
10		30. Name and address of person who co	dardensh	AS 0	Print) AUS Stave	w Ave,	were	MM	iten ni	D, aust	
St Regist	ate trar	31. Date filed (Month, Day, Year) APR 0 5 20	32. Registrar's Sign	iung .	book	61					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 1 1 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Yeer Physician Mary Roha11 April 1, 2004 12:15 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb 7, 191 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🙀 F 233-09-3076 88 1916 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-f show id other than "neturel", or items 23s or 28s-f show event, the Medical Examiner must be notified at 1. Yes 2 No Directo MD Montgomery Bethesda 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 76201 Old Georgetown Road #115 20814 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or item any injury or other treumatic event, the Medical Exemplem ance. Black White etc. 1 ☐ Yes 2 ☐ No If Yes, Give X 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary 12 Union Affiliates 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Michael Rohall, Sr. Mary Lesko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4317 Steuben Woods Drive Steubenville, OH Herb Rohall - Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) St. Nicholas Cemetery 4-5-04 Weirton, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Greco-Hertnick Funeral Home Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3219 Main Street Weirton, 26062 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiopulmonary Arrest Immediate /Medical Due to (or as a consequence of): **Examiner** 3-5- Days Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hypotension & Shock The law requires that the death certificate be executed for use as the burial-transil 1 Day the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Congestive Heart Failure Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 ☐ Live birth Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2X No 9 ☐ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Possible Recent Stroke and Altered Mental Status 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed Anemia and Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 XNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospitei or Attending Physicien: Within 24 hours after death. To the Funerel Director: After this cantion 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4-1-04 5360 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohsin Ijaz, MD 11119 Rockville Pike #100 Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 05 2004 outs Registrar

Mary Rohall

S			Please T	ype or Prir	nt in Black	cInc	delible Ink.	Ensure	All Copies	s Are	Legible.		
YN	MARIE	RE	Registrar	State of Ma	aryland / D	epa Cer	irtment of F	lealth and Death		Reg. No	2004	10250	
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Kaylyn Marie Reas	ons					2. Date of D Month APRI	Da	_	3. Time of Death 0520 A M	
	Examir		4a. Facility Name (If not institution, give s 602 CARROLLWOOD R		A		4b. City, Town, o ESSEX	r Location of Dea	ith		:. County of Death BALT IMORI		
	Funeral Director		213 17 1730		e (In yrs. last birth 9 Y	hday) (rs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		ley, Year,	Cou	plece (State or Foreign Intry) Land	
	Maryland Ited at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore	<u> </u>	10c. City, Town		cation					10d. Inside City Limits 1 ☐ Yes 2X No	
	ith with the 23a or 28s	rai Director	10e. Street and Number 602 "Apt.A" Carroll	lwood Rd.			10f. Zip Code 21 22	20			itizen of What Cou USA	intry?	
980	be filed within 72 hours after death with the Maryland nat Hygiene. do other than "natural", or itema 23a or 28a-f show event, Ira Medical Evaluation from that the routing at	i by Funerai	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	t Ever in U.S. ? 13. Was Decedent of Hispanic Origin? (Specify No 1 ☐ Yes 2 ☑ No Specify:					0-	14. Race - Ameri Black, White Specify: Wh:			
1215-0	within 72 ho ene. than *natu tha Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		((edent's Usual Occupation s kind of work done during most of w DO NOT use retired)		orking		ail Sale	,	
Maryland 21215-0036	ould be filed within Mental Hygiene. arked other than ' atic event, It a Me	To Be Co	12 Cashier 17. Father's Name (First, Middle, Last) Bobby LeDare Reasons, Jr. Kimberly Lynn 1							e, Maider	:5		
	and 2 should salth and Men n 27 is marke ier traumatic		19a. Informant's Name/Relationship (Typ. Kimberly Lynn Kambe		ther) 703	3 V		and Number or F Ave. Bal	timore,	Md.	21221		
Baltimore,	Pages 1 ment of He ant: If Iter ury or oth		1 Surial 2 Cremation 3 Removal from State Parnell Cemetery 4/10/2004 1 Surial 2 Cremation 3 Removal from State Parnell Cemetery 4/10/2004 1 Signature of Funeral Service Licensee // 22 Name and Address of Facility								ocation - City or T Bruceton t Virgin	Mills	
Bal	Departi Departi Importi any Inji		23a. Pa/t1. Enter the disease, or complic	ruzdzinsk 407 Old E	i Funera Lastern 1	Avenue E	ssex	, Md. 21	221 Approximate				
**	Physician /Medical Examiner	100	Sphock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as	ne. \$ a consequence of	f):		g,				Interval Between Onset and Death	
68760,	ate be executed thysician and the burial-transit	edicai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
.O. Box	that the death certificate to the by the attending physic detached for use as the botters.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Sayes 2 No 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Nhnown	2 Fetal death		Ectopic pregnancy Other (specify)				23d. Date of deliv Month	ery Day Year	
rds, P	sign d be	by	Part II. Other significant conditions commoding to death out not resulting in the underlying cause given in Part II.									use contribute to the cause of death? No 3 Probably 4 Unknown	
Vital Records,	The law ate has b page 2 s	24a. Was an autopsy performed?									24b. Were autopsy findings available prior to completion of cause of death? 123 Yes 2 □ No		
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:			Oth	or	ath (Check only				
Division of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	ertification; To	A Talliand Tollie 2 Live diparter 50 DON 4 Live 19 Live 3									al Route Number,	
	Hospitat or 24 hours after Funeral Distely filled in	dical Cer	29a. Certifier 1 Certifying Physic (Check only 2 XMedical Examin	icien: To the best of	home of my knowledge,	death	occurred at the tin	ne, date and plac	e, and due to the	cause(s)) and manner as s	d JES SEX, italed.	
)	To the twithin 24 To the F	Medi	29b. Signature and title of certifier Josha J.M.	and manner sta	ted.		29c. License			29d. Da	te signed (Month,	Dey, Year)	
	40		30. Name and address of person who cor Tashaz Greenbe	mpleted cause of de	eath (Item 23a) (T	Type, F	Street,	Baltimo	re, Mar	/land	1 21201		
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5 2004	32. Registra	ar's Signature	20	och!						

			1 - For State Registrar	State of N	Marylar	nd / Depa <i>Cei</i>	artment of F	lealth and I Death	Mental Hy	giene 2	004	10251
	Physici		Decedent's Name (First, Middle, Last) Francis Patrick F		III				2. Date of De Month		Year 04	3. Time of Death 12.35 AM
	/Medic Examin		4a. Facility Name (If not institution, give s			^	Rosedo			4c. Cou	nty of Death	
63	Funeral Director		5. Social Security Number 6. Sex 216 26 7696		Age (In yrs. 64	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec, 21	ıy, Year)	9. Birthp Coun Mary	
	Aaryland f show	ŏ	10a. State 10b. County Maryland Baltimore	2		ty, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2X No
	death with the Maryland me 23a or 28a-f show rmat be notified at	Director	10e. Street and Number 206 "Apt1B" Middle				10f. Zip Code 21 22	0		10g. Citizen		itry?
G. 0		Funeral	-	12. Was Deceder Armed Force 1 Yes 2 [s?		Was Decedent of Hilf Yes, specify Cuba		pecify Yes or No o Rican, etc.))- 14. F	Race - Americ Black, White,	etc.
Nolds Francis F Maryland 21215-0036	within 72 hours after ene. then "natural", or Ite	leted by	3 ☐ Widowed 4 💆 Divorced 15. Decedent's Edu (Specify only highest grade	Year or Date:	s:	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation	rking		cify: Whi	
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ds/	should be Ind Mental I	To Be	Francis Patrick Rey		I	19h Mailir	ng Address (Street	Ruth A	gnes Sch	ehlein		Codel
	1 and 2 s Health an em 27 is the		Ruth Agnes Reynolds 20a, Method of Disposition		20b. F	206 Place of Dispo	'Apt 1B''	Middlewa		ltimor		21220
$\beta \mathcal{W}^{\lambda}$ Baltimore,	t. Pages dment of l rtent: # It njury or o		1 ☐ Burial 2 【Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign Aure/of Funeral Service License		10	view C	ratory or other place crematory	4/6/		Baltim		aryland
Ba	permit. Depart Import any inj		23a Part 1. Enter the disease, or compli	rkows	ke		2. Name and Addre Bruzdzins 1407 Old	Eastern)	Avenue E	ssex,	Md. 21	221 Approximate
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rds, P	v requires that been signed b should be deta	ed by Pi	Part II. Other significant conditions con COPD Lung S	stributing to death	_	sulting in the u	nderlying cause giv	en in Part I.		obacco use co Yes 2 No		e cause of death?
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f Vita	Physician: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital: 1 🔣 Inpa	atient 2]ER/Outpatier	nt 3 DOA Oth	26. Place of Dea er: 4 ☐ Nursing H	ith (Check only o		Other (Specify	()
ion o	ttending Ph death. ctor: After th y the funeral	atlon:	27. Manner of Death 1 【Natural 5 □ Pending 2 □ Accident investigation	28a. Date of II (Month, I	njury Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe	how injury occ	curred	
Divis		Certification:	3 Suicide 6 Could not be 4 Homicide determined	building,	etc. (Speci	fy)	reet, factory, office		City or To	wn, State)		l Route Number,
1	the Hospitel hin 24 hours a the Funeral i	Medical	29a. Certifier 1 ★ Certifying Physical (Check only one)	sician: To the be ner: On the basis and manner	s of examina	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and date and plac	manner as st e, and due to	ated. the cause(s)
	with To t	Σ	29b. Signature and title of certifier Much D Ta	t- ,	M. C		RES	o number 00000)	29d. Date sig	ned (Month, I	Day, Year)
	14			hanmi	of death (Item	1 4	Print)	are Dri	re Bal	Himore,	Md.	21237
	Sta Regist		31. Date filed (Month, Day, Year) APR 0 5 2004		strar's Signa	ature	Some	,				

ecords, P.O. I law requires that the de as been signed by the a	by Phy	Part II. Other significant conditions con	ntributing to death but	not resulting in the	underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Box ath cert	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ≥ No 9 □ Unknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death 3	☐ Ectopic pregnanc	sy		23d. Date of de Month	ivery Day Year
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Baltin permit P Deparme Imporan any in uri		21. Signature of Funeral Service License	/ cours	/,	RUCK TOW	ess of Facility	ral Hor	ne, Inc.	1050 York Towson,Md.
Baltimore, Maryland 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Imporant: if item 27 is marked other than "natural; or items 23e or 28e-f show any injury or other traumatic event, it a Medical Examinar mastice routilise at once.		John E. Roland , 20a. Method of Disposition 1 Yeurial 2 Cremation 3 R 4 Donation 5 Other (Specify)	Husband	20b. Place of Disp cemetery, cr	position (Name of ematory or other pla	ice)	ite 2	0c. Location - City or	
faryla 2 should 1 and Me 1s mark	2	19a. Informant's Name/Relationship (Ty)	_			t and Number or Rural	Route Number,	City or Town, State, 2	_ , _ , _
and the file of the other of the other oth	Be	17. Father's Name (First, Middle, Last) Robert Dumm				18. Mother's Name	First, Middle, M, Kensir		
d 2121 filed within Hygiene. other than	Completed	Elementary/Secondary (0-12)	Cottege (1-4or 5+) +4			_{d)} Nurse	Ed	ducation	in Nursin
5-003	eted by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade	If Yes, Give Year or Dates: cation	16a. Dec	edent's Usual Occur		g 1	6b. Kind of Business/	Jhite Industry
-0036 hours after death with the Maryland turer, or flems 23e or 28e-f show at Exeminer must be notilied at	Funeral Director		2. Was Decedent Eve Armed Forces? 1 X Yes 2 □ No		Was Decedent of H If Yes, specify Cub-	Hispanic Origin? (Specan, Mexican, Puerto R Specify:	ity Yes or No- ican, etc.)	14 Race - Ame Black, White Specify:	
with the Sa or 28	i Dire	10e. Street and Number 2147 Suburban (Greens Dr	rive	10f. Zip Code 21093		10	g. Citizen of What Co USA	untry?
Marylan a-f show	ctor	10a. State 10b. County Maryland Baltimo		Oc. City, Town or Luther\					10d. Inside City Limits 1 ☐ Yes 2 No
Director		Usual Residence of Decedent	M 2 XF 77			Tiours Iviii.	Sept. 3	3,1926 Pe	ennsylvania
Funeral		Gilchrist 5. Social Security Number 6. Sex	-	In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day,	Baltimo	hplace (State or Foreign untry)
/Medic Examin	- 20	4a. Facility Name (If not institution, give s				or Location of Death	3111 0	4c. County of Deat	h
Physici		1. Decedent's Name (First, Middle, Last) Patricia Ann	Polond				2. Date of Death Month Dril 3.	Day Year	3. Time of Death 9:50 P M
· · · · · · · · · · · · · · · · · · ·		State Registrar	State of Ivial	yland / Dep <i>Ce</i>	rtificate of	Death	Reg	3. No. 2001	3. Time of Death

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		1 - State unpenditem#		er ME,C830,	ertificate of				10253
Physici	an .	1. Decedent's Name (First, Middle Brenda Kay	Reynolds				Date of Death Month	Day Year	3. Time of Death
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Examin	er	Anne Arundel I	_			apolis		Anne Aru	
Funeral Director		5. Social Security Number 229-78-2752	6. Sex 7. Aq 1 ☐ M 2 ☐ F	ge (In yrs. last birthd 49 Yrs	Months Oave	If Under 24 Hrs. Hours Min.	8. Oate of Birth (Month, Day, April 29	9. Birt (Co), 1954 M	thplace (State or Fore ountry) aine
100		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d Inside Ois Live
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Inter then *natural*, or items 23a or 28a-f show ont, the Medical Exameter maint be notified at	ō		Anne's		rensville				10d. Inside City Lim 1 ☐ Yes 2 ☐ I
r 28a-	rect	10e. Street and Number	Mille 3	blev	10f. Zip Code		10	g. Citizen of What Co	untry?
th with	Funeral Director	1502 Marion Qui	inby Drive		21666	5		USA	
ler dea	nner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 1	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
s afte	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	ed 1 Yes 2 I	No	1 ☐ Yes 2 🛣 No	Specify:		Specify	White
72 hours natural*		15. Decedent	s Education	16a. De	cedent's Usual Occup	pation	10	6b. Kind of Business/	
s within 72 housene.	Completed	(Specify only highes Elementary/Secondary (0-12)	completed) College (1-4or	5+) (G	ive kind of work done ONDT use retire	during most of working d)	g		
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be filed htal Hygi ed other event,	Be	17. Father's Name (First, Middle, L James Cyrus	.ast)			18. Mother's Name (aiden Sumame)	
es 1 and 2 should be filed of Health and Mental Hygis I item 27 Is marked other r other traumatic event, II	7	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. M	ailing Address (Street	and Number or Rural		City or Town State 2	7in Code)
and 2 s ealth ar n 27 is ner trau		Jennifer Alicea				water Road			
os 1 and 2 of Health item 27 l		20a. Method of Disposition		20b. Place of Dis	sposition (Name of crematory or other place	Da		Oc. Location - City or	
0=:0		1 ☐ Burial 2 【XCremation `4 ☐ Donation 5 ☐ Other (Sp		' -	uneral Hom		-04	Lynchburg	, VA
permit. Pa Departmer Important any Injury		21. Signature # Funeral Service L	icensee	000	22. Name and Addre	ss of Facility Ineral Home			
70 = 4 d		men	hood		220 Bree	zewood Dr.	Lynchb		
		23a. Part1. Enjoy the disease, of shock, or heart failure. List of immediate Cause (Final	only one cause on each I	ine.		ng, such as cardiac or	respiratory arres	51,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a	ug Intoxica	tion				
Examiner			Due to (or as	a consequence of):					
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or Attending Physician: The law requires that the death certificate the death. Director: After this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		_			23d. Date of deli	iverv
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that the ded by the detached	hys	9 Unknowh	9□ Unknown						
res tha igned be de	by	Part II. Other significant condition	ns contributing to death I	out not resulting in the	e underlying cause giv	ren in Part I.		icco use contribute to	
w requir been si should	eted						1 L Yes	2 No 3 Pr	
e law has b	ompieted						24a. Was an autopsy performe	prior to d	topsy findings availa completion of cause
ician: The l certificate ha ector, page	e Co	25. Was case referred to medical		·			1 Yes 2	□No 1997es	2□ No
ysician: is certific director,	o Be	examiner?	Hospital: 1 ☐ Inpati	ent 2 TER/Outpa	tient 30 DOA Oth	26. Place of Death /		ce 6 □Other (Spec	
g Phy er this	-	27. Manner of Death	28a. Date of Inju	The second second	of 28c. Injur		d. Oescribe how		лі у)
ittending I death. ctor: After / the funer	Certification;	1 □Natural 5 □ Pending 2 □ Accident investig	ation found 3/2	2/04 unkn		Yes 2. Mg No SL	ibject ing	ested drugs	
or Atto	rtific	3 XSuicide 6 ☐ Could n 4 ☐ Homicide determi	ned building, e	jury - At home, farm, tc. <i>(Specily)</i>	street, factory, office	28	City or Town,	et and Number or Ru State)	
pital c urs af eral D			Physicien: To the best			Si	XV Marian	n Cubeern Beee L	r.,
Hosi 24 ho Fund Hely f	Medical	29a. Certifier 1 Certifying (Check only 2 Medical E	proviner: To the best exeminer: On the basis of and manner si	of examination and/or	eath occurred at the tir r investigation, in my o	me, date and place, an pinion, death occurred	nd due to the cau d at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th	Me	29b. Signature and title of certifier			29c. Licens	e number		d. Date signed (Month	
- > - 0		1 / la Ro	nO		00	ME		March 23 2	2004
		A A .	who completed cause of	death (Item 23a) (Typ					12 01001
			KEMA			enn Street,	, Baltim	ore, Mary	land 21201
Sta Registr		31. Date filed (Month, Day, Year)	2004 32 Regist	rar's Signature	made				

		•	1 - For State Registrar	State of Ma	aryland		rtment of F		nd Mental Hy	giene Reg. No. 2 (004	10	254
			1. Decedent's Name (First, Middle, Last	1)		-			2. Date of De	aath	Year	3. Time of	f Death
204	Physici /Medic	-	Eleanor Jane Rea	am					April	3 20	04	8:15	РМ
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	r Location of	Death	4c. Coun	ty of Death		
	. 2		7 Sampson Place				Annapo		(Uso T a second		Arun		
	Funeral		5. Social Security Number 6. Se	x	je (In yrs. la: 78	Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bit Min. (Month, Date of Bit	2, 1925	9. Birth	place (State ontry) .nois	or Foreign
Mari	Director		351-18-8134 Usual Residence of Decedent						July 2	2,1923	1 7777	.11015	
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside C	ity Limits
	a-fs	Director	MD Anne Arı	ınde1	A	nnapo	lis					1 🗌 Yes	2 💢 No
	or 28	Oire	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntry?	
	ath w	Ta l	7 Sampson Place				21401			USA			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28a-f show sary injury or other treumatic event, the Modical Examiner man be notified at ODGe.	by Funeral	11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Y If Yes, Give Year or Dates:			Nas Decedent of H f Yes, specify Cuba I □ Yes 2X1 No	ispanic Origii an, Mexican, i Specify:	n? (Specify Yes or No Puerto Rican, etc.)	Spec	ice - Ameri ack, White, ify: Wh		
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3	d Mer nark	ဥ	Frank Sturgon 19a. Informant's Name/Relationship (T	una Print)		10b Mailir	Address (Street		a Mae Coun or Rural Route Numb		State 7in	Code	
Ma	d 2 sl th and th and treur		Stanley Ream (Hu						nnapolis,			(2008)	
re,	Heal Heal tem 2		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name of natory or other place		Date	20c. Location		own, State	
OE.	Pages ent of ht: If i		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,			•	Veterans	·	/7/2004	Crowns	wi11a	MD	
Baltimore,	mit. F partm porter / Injur		21. Signature of Funeral Service Liquit		riar y		. Name and Addre	ss of Facility			VIIIC	, III	
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•			Mary	Due			D5	1819		Apr	1 5	7,20	04
	5		30. Name and address of person who o	completed cause of	death (Item 2	23a) (Type,	Print)	napil	is MD	214	4/		
	Sta Registi		31. Date filed (Month, Day, Year) 5 2004		rar's Signatu	re fg	Soon	/	is MD				

			For State Registrar	State of M	larylan	•	artmen rtificat			and M		giene 2	004	10255
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L.	Funeral Director				ge (In yrs. 88	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Da) 08/2/1	, Year) . 915	N/A 9. Birthp Cour M	
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County N/A		10c. Cit	y, Town or Lo		timo	re Ci	.ty			1	I Od. Inside City Limits NXYes 2 □ No
	h with the 23a or 28 st be no	al Director	10e. Street and Number 1401 Andre Street				10f. Zip	Code	21	230		10g. Citizen o	of What Cour USA	ntry?
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21215-0036	ad within 72 h gjene. er than "natu i, the Modical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		5+)	16a. Dece (Give life.	kind of wo. DO NOT us	rk done d se retired) emake	uring most e r			16b. Kind of	Own H	
Maryland	should be filed nd Mental Hygi s marked other umatic event, I	To Be (17. Father's Name (First, Middle, Last) Maxamillion Staff	ā		18. Mother's Name (First, Middle, Anna Sha							ame)	
	and 2 sho ealth and n 27 is ma		19a. Informant's Name/Relationship (Ty, Barbara Martin /I				-				Route Numbe	-		Code)
Baltimore,	nit. Pages 1 autment of He ortant: If Item njury or oth		20a. Method of Disposition 1 urial 2 Cremation 3 R 4 Donation 5 Other (Specify)		Lake	Place of Dispo cemetery, crei View C	natory or o	ther place	5, 200		ate	20c. Location	n - City or To Ville,	
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of Vita	nysic lis ce direc	To Be	25. Was case referred to medical examiner? 1 Yes 2 F	lospital: 1 npat	ient 2□	ER/Outpatier		-	r: 4 🗆 Nu		<i>(Check only o</i> ne 5 ☐ Resid		ther (Specify	y)
ion c	ding P. After fune	atlon;	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury	м 2	28c. Injury Work 1 □ Y	at ? es 2 □ t		8d. Describe h	ow injury occ	urred	
Division	tel or Attender: s after deatlel Director: ed in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	njury - At h		eet, factory	y, office		2	8f. Location (S City or Tow	itreet and Nur n, State)	mber or Rura	l Route Numb e r,
7	To the Hospitel or Al within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sician: To the bes ner: On the basis and manner s	of examina	wledge, deat ition and/or in	h occurred vestigation	at the tim , in my op	e, date and inion, deal	d place, a th occurre	and due to the ded at the time, o	cause(s) and i	manner as si e, and due to	tated. o the cause(s)
)	To the vithin 2 To the complet	Σ	29b. Signature and title of certifier Parca A.	M		HID	· R	ES.		1		April	ned (Month,	2004
	V		30. Name and address of person who co	r 3	001	Sat	4	Han	Over	. 5	street	-	<u> </u>	
	State Registrar David A Wyler 3001 South Hanover Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 0 5 2004													

Christian Smallwood 04-02266 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10256 crn State of Maryland / Department of Health and Mental Hygien [] 1 4 For State Registra Certificate of Death 2. Date of Death 3. Time of Death April Day 01 Physician 2004 10:04 PM 1/42000 AUU /Medical 4c. County of Death 4b. City, Town, or Location of Death la. Facility Name (If not institution, give street and number) Examiner N/A Johns Hopkins Hospital Baltimore 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Yrs. 5. Social Security Number **Funeral** Days Hours 1 M 2 □ F 0-11-0408 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 No 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number or items 23a To Be Completed by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: t of Hispanic Origin? (Specify Yes or No-Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) in 2 should be filed within in and Mental Hygiene. College (1-4or 5+) KNOWN 18. Mother's Name (First, Middle, Maiden Sumame 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee permit. 23a. Part1. Enter the disease, of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence f): Examiner Be Completed by Physician/Medical Examiner page 2 Certification: To

Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After To the hosping after death.
To the Funerel Director: Aft

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significent conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1
25. Was case referred to medical	26. Place of D	Death (Check only one)
examiner? 1X Yes 2 No	Othor	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigat		28d. Describe how injury occurred Subject Shot
3 ☐ Suicide 6 ☐ Could not determine		28f. Location (Street and Number or Rural Ropte Number Community State)
29a. Certifier 1 ☐ Certifying (Check only conf) 2 ☐ Certifying 2	Physician: To the best of my knowledge, death occurred at the time, date and pla eminer: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	ace, and due to the cause(s) and manner as stated. ccurred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

Darksi

O.C.M.E.

Valla Penn Street, Baltimore, Maryland 21201

April 02, 2004

Registrar DHMH 17 Rev 1/2001

State

To the

(Item 23a) (Type, Print)

30. Name and address of person who completed cause of death

son, ar

32. Registrar's Signature

AL

APR Q 5. 2004

31. Date filed (Month, Day, Year)

hysici: /Medic		1. Decedent's Name (First, Middle, Las	PER PHY G830 4/08/04 Ladek		2. Date of De Month AFR	IL E, EZW	24 5:00
xamin	er	4a. Facility Name (If not institution, give Saint Joseph	Medical Center	4b. City, Town, or Location o	of Death DWSON	4c. County of De	eath ltimore
neral ector		210-10-3001	ex 7. Age (In yrs. last bii 81	thday) If Under 1 Year If Under 3 Yes. Hours	Min. 8. Date of Bir (Month, Date of Bir (Date of Bir (Month, Date	9. E 5, 1922 M	Birthplace (State or 1 Country) Aryland
or 28a-1 show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo	10c. City, Tow	n or Location Parkville			10d. Inside City
a or 288 Uburuti	Direc	10e. Street and Number 7820 Old Harford	d Road	10f. Zip Code 2123	14	10g. Citizen of What	
ortant: if tiem 27 is marked other than "nature", or teems 2.a or 28a-1 shot injury or other traumatic event. The Madical Examinations instituted at a second secon	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (X) No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☒ No Specify:		14. Race - Ar Black, Wi	merican Indian,
a Madical E	Completed	15. Decedent's Ed (Specify only highest gra		Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired) Homemaker	t of working	16b. Kind of Busines	
matic event. the Ms	To Be Co	10th Grade 17. Father's Name (First, Middle, Last) Harry Itzoe		18. Mothe	ir's Name (First, Middle Lizabeth		me
traume		19a. Informant's Name/Relationship (1988). Barbara School		o. Mailing Address (Street and Number 18 Clearview Ave.			
any injury or other		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐	20b. Place o	f Disposition (Name of ry, crematory or other place)	Date	20c. Location - City	or Town, State
jury o		* 4 □ Donation 5 □ Other (Specify	y) Most H		1/5/2004	Baltimore	
any in		21. Signature of Funeral Service Licen	· 4	22. Name and Address of Facility	Schimun Balt MD	rela Funer	al Home
cian		23a. Part 1. Enter the disease or com, strick, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death. Do one cause on each line.	not enter the mode of dying, such as	cardiac or respiratory a	arrest.	Approximate Interval Betw Onset and D
lical iner		resulting in death)	Due to (or as a consequence	of):			
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IUSII	Examiner	Cause (Disease or injury	CONGESTIVE H	FART FATILIRE			YEARS
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ched for use as the burial-tra	cal	that initiated events	· ·	on: ERY DISEASE		23d. Date of o Month	
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			1 - State Registrar	<i>C</i>	ertificate of		Reg. I	vo	3 Time of Dooth
	Physici	an	1. Decedent's Name (First, Middle, Last)	<	ANDER		Month Month	81, 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)			or Location of Death		4c. County of Death	
			maryland General N	Lospital		more		N	IA
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 X F	e (In yrs. last birthda 73 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Yee	9. Birth Cou	nplece (State or Foreign Intry) RTH (ARCLIA
	D		Usual Residence of Decedent	\sim		L C	rang i	720,700	
	with the Maryland is or 28a-f show	2	10a. State 10b. County	10c. City, Town or	Location	TI \$ 100	- 1.7	-V	10d. Inside City Limits 12 Yes 2 □ No
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ر کے)	ems 23	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 1	Was Decedent of H If Yes, specify Cuba	dispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Amer Black, White	
大 %	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: if itsm 27 is marked other than "natural", or Items 23s or 28a-f show sny injury or other traumatic event, the Medical Examinat must be rediffed at once.	by Fu	1 Never Married 2 Married 1 Yes, 2 ↑ If Yes, Give Year or Dates:	ΝO	1 ☐ Yes 2 🗷 No	Specify:		Specify:	PCK
2 6	72 hou natura dical E	ted	15. Decedent's Education (Specify only highest grade completed)	16a. De	cedent's Usual Occup	pation	16b.	Kind of Business/li	ndustry
215	within 7 ene. than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5	5+) life	1	during most of working		2011	Hans
d 21	filed with Hygiene other the	Co	17. Father's Name (First, Middle, Last)		IOME	MAKER 18. Mother's Name		len Sumame)	HOME
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lary	2 should and Mer is marks aumatic	Γ	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Street	and Number or Rural	Route Number, Cit	y or Town, State, Zi	
, S	1 and 2 Health sm 27 i		DENISE THOMAS WAUGH 20a. Method of Disposition	17ER) / S	sposition (Name of	AFAYET	TE AVE.	Location - City or T	MD 21211
Saltimore	Pages nent of h int: If its		1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	cemetery, c	crematory or other plac			ALTIMOR	
~ / i	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee	N. LOUDON	22. Name and Addre	ess of Facility	BANN	JJR.Fi	NEDA HOW
ä	Departing the post of the post		Watrich N. Will	lan	2998	J. FULTO.	JAVE.	BALTO!	TU LIXII
			23a Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lire	I the death. Do not ne.			respiratory arrest,		Approximate Interval Between Onset and Death
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9.	that the	y Ph	Part II. Other significant conditions contributing to death b	out not resulting in th	e underlying cause giv	ven in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
rds	quires an sign uld be	ed b					1 🗆 Yes	2 □ No 3 □ Pro	obably 4 nknown
ဝင္ပ	law re as bec 2 sho	Completed					24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
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o to	g Physer this eral di	n; To	1 Ves 2 No 10 No 10 No 11 Minpatie 27. Manner of Death 28a. Date of Inju	ry 28b. Tim	e of 28c. Injur	ry at 2	e 5 Hesidence	6 ☐Other (Special of the following occurred oc	ny)
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Division of Vital Records,	al or Attendia after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, et	jury - At home, farm, tc. <i>(Specify)</i>	, street, factory, office	2	Bf. Location (Street City or Town, St	and Number or Rui ate)	ral Route Number,
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pr	To the Hospital or Al within 24 hours after or To the Funeral Direct completely litted in by	Medical	(Check only one) 2 Medicef Exeminer: On the basis o and manner str	of examination and/o					
	To the within 2 To the comple	Σ	29b. Signature and title of certifier		29c. Licens	se number	29d. l	Date signed (Month	, Day, Year)
	1		171 (488sam	da an (0.00 co.) =	89	414	,	213110	4
			Shahr and address of person who completed cause of a	death (Item 23a) (Ty	aniland	Genera	1 Hospi	tal	
		ate	31. Date filed (Month, Day, Year) 32: Registr	rar's Signature	Par de				
	Regist	rar	1600 0 5 2001 Depen	The first	payours				

ORIGINAL

			1 - State Registrar	State	of Marylar		artmen <i>rtificat</i>			nd M	ental Hygi	ene g. No. 4	2004	10259
	Physici /Medio		Decedent's Name (First, Middle POLLY MAE	SCOTT							2. Date of Death Month APRIL	Day 2	Year 2004	3. Time of Death
	Examin Funeral	ner	4a. Facility Name (If not institutio MILLENNIUM OF 5. Social Security Number	ELLICOTT 6. Sex		last birthday)	EL If Under	LICOT	Location of CT CIT If Under 2	Y 4 Hrs.	8. Date of Birth		HOWARD 9. Births	place (State or Foreign
	Director		220-18-5301 Usual Residence of Decedent	1 □ M 2 🖾 F	94	Yrs.	Months	Days	Hours	Min.	(Month, Day, 9-22-		Cou	GA
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חשווווי	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is eny injury or other trau		1 LoBuriai 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (5 21. Signature of Funeral Service	Specify) Licensee	Morto	NATIO 22	NAL M 2. Name ar 701-3	EM. d Address	PK. 4 s of Facility URENS	JAM ST.	ES A. MO BALTIN	ORTO 10RE		S F.H., INC. AND 21217
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NISION OF VI	Il or Attending Physicien: The after death. Director: After this certificate hi d in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendii investi 3 Suicide 6 Could 4 Homicide	Hospital: 1 Can gation not be sized 28e. Place	Inpatient 2 C e of Injury nth, Day Year) ce of Injury - At h ding, etc. (Speci	28b. Time of Injury	M 2	8c. Injury Work 1 🗆 Y	r: 4 Nurs	ing Hom 2	(Check only one ne 5 Resident 8d. Describe how 8f. Location (Stre City or Town,	ice 6 [occurred	
i y	To the Hospital or within 24 hours after to the Funerel Discompletely filled in	Medical Cer	29a. Certifier (Check only one)	ng Physician: To the Examiner: On the and ma	ne best of my kno	owledge death	occurred vestigation	at the time	e, date and inion, death	place, a	and due to the ear		nd manner as st ace, and due to	ated. the cause(s)
1	With To I	Z	29b. Signature and title of certific	1	m	0	290	Cense	27	46	290	d. Date s	signed (Month,	ared. The cause(s) Day, Year) DOD 4 WD 7/D4
,	4		30. Name and address of person	brik	720	m 23a) (Type,	Print)	en	Ch	050	elan	e .	bels	workey
	Sta Registr		31. Date filed (MAN) Payor Sar	2004 32.	Registrar's Sign	ature	do	and	/					

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- 1	U	-	O	ŧ

				1 - For State Registrar	State of h	viaiyiaii		tificate of			Reg. No.		10200
		Dhusisi		1. Decedent's Name (First, Middle,	ast)					2. Date of De Month	Day	y Yeer	3. Time of Death
		Physicia /Medic		Cha	rles Regi	inald	Sumne	r		March	24,	2004	2:30P M
-		Examin		4a. Facility Name (If not institution, g	give street and number	er)		4b. City, Town,	or Location of Deeth	1	4c.	. County of Death	
				Layhill Center					Spring			ontgomer	
		Funeral		Social Security Number 6	.Sex 7 12∑M 2□F	Age (In yrs. I		If Under 1 Year Months Days		(Month, Da	th y, Year)	9. Birth	plece (State or Foreign intry)
	5	Director		215-26-0798	20.	78	Yrs.			Sept.	9,19	25 Wash	ington, DC
		and *		Usuel Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
		sho	ក				C + 1	om Comio	~				1 ☐ Yes 2 ☐ No
		he N	Director	Maryland Montgo 10e. Street and Number	mery		STIV	er Sprin	8		10g Citi	izen of What Cou	
		a or	급			101		· ·					
7		eath	Funerai	12015 Veirs Mill 11. Marital Status	12. Was Decede		S. 13 V	2090		pecify Yes or No		ted Stat	
R		lter d	S	1 Never Married 2 Married	Armed Force	s?			Hispanic Origin? (Si pan, Mexican, Puert	o Rican, etc.)		Black, White	
10 Din	5-0036	irs af	by	3√ Widowed 4 □ Divorced	1 X Yes 2 [If Yes, Give Year or Date	s:		I□Yes 2X No	Specify:			Specify: Wh:	ite
1	ŏ	2 hou	ed	15. Decedent's	Education		16a. Deced	lent's Usual Occu	pation	4.1	16b. Ki	ind of Business/Ir	ndustry
3	215	7 uir G	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4c	or 5+)	life. I	kind of work done DO NOT use retire	during most of world)	king			
`	212	d with	E	10	College (1140	51 5 + 7	Mast	er Uphol	sterer		F	urniture	
\	P	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "naturel", or Items 23e or 28e-f show event, the Medical Examinar must be mailified at	Bec	17. Father's Name (First, Middle, La	unk)				18. Mother's Nan	ne (First, Middle	, Maiden	Sumame) (u	ınk)
0	lar	Aenta Aenta rked tic e	ToE										
3/24/04	Maryland	s 1 and 2 should be filed within Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Addrass (Stree	t and Number or Ru	ral Route Numb	er, City o	or Town, State, Zi	p Code)
CX	-	alth 27		Thomas L. Sumner						Apt.10	1;Si	lver Spr	ing, MD 209
10	ē	as 1 and 2 of Health I tem 27 I		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other pla	ice)	Date	20c. Lo	ocation - City or T	own, State
(V)	E	Page nent c nt: If		1 ☐ Burial 2 XX Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe		110			atory 03/	29/2004	Bre	entwood.	MD
A	Baltimore,	permit. Pages 1 a Department of He- Important: If Item any injury or othe		21. Signature of Funeral Service	a nsee	,			ess of Facility Ibute Fun				
DOD	Ö	9 0 E 8 9		Centry	Living	-	1	040 Rock	ville Pik	e; Rock	vill	e, MD 20	1852
12	4	(6).		23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that cause	sed the death	. Do not ent	er the mode of dy	ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	B	Physician		Immediate Cause (Final	,		[0 M D T T T T						Onset and Death
V	7	/Medical		disease or condition resulting in death)	- W	as a consequ	Larnyx Jence of):						
	die.	Examiner			Mass	in Li	ver						
			je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		as a consequ							
		outed od ansit	Examiner	Cause (Disease or injury that initiated events	c. Pneum	nonia							
	ó	an ar	EX	resulting in death) Last	Due to (or	as a consequ	uence of):						
	68760,	tificate be executed ig physician and as the burial-transit	edicai		d. Failı	ire to	Thriv	e					
		ntifica ng ph as th	Jed	IE ECHALE.		· · · · · · · · · · · · · · · · · · ·							
2	Вох	eath cert	hysician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1 ☐Live birth			Ectopic pregnanc	ev.		1	23d. Date of deliv	
3		deal	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		t at time of de		Other (specify)				Month	Day Year
2	P.0	that the de led by the a detached f	Phy	9 Unknown									
UMAR		requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	by 6	Part II. Other significant condition	s contributing to death	h but not resu	alting in the u	nderlying cause gi	ven in Part I.	1			the cause of death?
5	Records,	v requir been si should	ed	Hypothyroidism						1	Yes 21	∐No 3∐Pro	bably 4X Unknown
V)	၁၁		ompleted	Anemia						24a. Was		24b. Were auto	opsy findings available ompletion of cause of
01		sician: The law certificate has b rrector, page 2 s	E O							perfo	rmed?	death?	
7	Vital	ian: rtifica	Be C	25. Was case referred to medical					26. Place of Dea				
S	-	Physician: this certific ral director,	To	examiner? 1 ☐ Yes 2X☐ No	Hospital: 1 🔲 Inpa	atient 2 🗌	ER/Outpatien	t 3 DOA	her: 4 🔀 Nursing H	ome 5 Resi	dence (6 □Other (Speci	fy)
Th	J of	ng Pt ter th		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	28c. Inju	ry at -	28d. Describe	how injur	ry occurred	
22	0	Attending r death. sctor: After by the fune	atic	2 ☐ Accident investiga	tion			M 1	Yes 2□No				
MANLES	Division	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 286. Place of	Injury - At ho	ome, farm, str	eet, factory, office		28f. Location (al Route Number,
1	ā	tal or rs afte al Dire	Cer		25.1								
U		the Hospital nin 24 hours a the Funeral I npletely filled		29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the be kaminer: On the basis	st of my kno	wledge, death	occurred at the t	me, date and place	, and due to the	cause(s)	and manner as s	stated.
	D	the H in 24 the F plete	Medical	one)	and manner	stated.							
		Viith To t	5	29b. Signature and title of certifier	~ 1. 1	1-		29c. Licen	se number		29d. Dat	te signed (Month,	Day, Year)
•	7	1		Moude	e pur	Keng	7	D56	691		Mar	ch 26, 2	.004
	.4	3		30. Name and address of person w	·			1000	00				
		9		Ghousia Sultana,	MD 121	Heri	tage/	ark irc	Silve	r Sprin	, M	D 20906	
		Sta Registe		31. Date filed (Mart PRy, 093	2004 32.	skar Signa	ture	popular					

Registrar

			1 - For State Registrar		artment of Health and rtificate of Death	Mental Hygiene	2006	10261
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Ruth Virginia Stor	ttlemyer		2. Date of Death Month Day March 28,	y Year 20004	3. Time of Death 8:25p M
	Examin		4a. Facility Name (If not institution, give street a	and number)	4b. City, Town, or Location of Deat Rockville		. County of Death Montgo	
	Funeral Director		Social Security Number 219−07−1044 Usual Residence of Decedent 6. Sex 1 □ M 2 2 2 Usual Residence of Decedent 2 2 2 2 Usual Residence of Decedent 2 Usual Residence of Deced	7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birth Cou 16 Mar	place (State or Foreign intry) yland
	Maryland -I show	tor	10a. State 10b. County MD Montgomers	10c. City, Town or L				10d. Inside City Limits 1
	with the	i Director	10e. Street and Number 11820 Eton Manor Dra	ive	10f. Zip Code 20876	10g. Cit	tizen of What Cou	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28e-f show amportant: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic avant, the Mcdical Examiner must be notified at once.	by Funerai	11. Marital Status 12. Wa		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes	Specify Yes or No- to Rican, etc.)	United 14. Race - Ameri Black, White, Specify: w	ican Indian,
Maryland 21215-0036	within 72 hou ene. than "nature ne Medical E	Completed	15. Decedent's Education (Specify only highest grade comp	pleted) 16a. Dece (Give life.	ndent's Usual Occupation a kind of work done during most of wo DO NOT use retired) Omemaker	rking 16b. K	find of Business/Ir	ndustry
yland 2	ould be filed Mental Hygi arked other atic avant, I	To Be Co	17. Father's Name (First, Middle, Last) Herbert Norwood		Ida J	me (First, Middle, Maiden ane Howard		
, Mar	and 2 shalth and n 27 is m		19a. Informant's Name/Relationship (Type, Pri Shirley Ann Julian/I	Daughter 118	ing Address <i>(Street and Number or Rt</i> 20 Eton Manor Dri			p Code) 20876
Baltimore,	Pages 1 ment of He ant: If itan iury or oth		20a. Method of Disposition 1 □ Burial 2 □ remation 3 □ Remova 4 □ Donation 5 □ Other (Specify)	zi ii Oili State	osition (Name of matory or other place) ncoln Crematory		centwood	
Ball	permit. Depart Import any Inj		21. Signature of Funeral Service Licentee	land !	2.Name and Address of Facility Simple Tribute Fu: 1040 Rockville Pi	ke Rockville	emation , MD 20	0852
l	Physician /Medical		resulting in death)	se on each line. Stroke	ter the mode of dying, such as cardian	c or respiratory arrest,		Approximate Interval Between Onset and Death Years
	Examiner	_	Sequentially list conditions b. C	Due to (or as a consequence of): Cerebrovascular I Due to (or as a consequence of):)isease			Years
760,	ate be executed physician and the burial-transit	i Examiner	Cause (Disease or injury that initiated events c. R	Recurrent Pneumor Due to (or as a consequence of):	nia			
89	rtificate b ng physic as the b	Aedicai	d					
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
rds, P	w requires that been signed b should be deta	b	Part II. Other significant conditions contributions	ng to death but not resulting in the u	underlying cause given in Part I.			he cause of death?
al Records,		Completed				24a. Was an autopsy performed? 1 ☐ Yes 2X No	prior to co death?	opsy findings available impletion of cause of
Division of Vital	To the Höspital or Attanding Physician: The within 24 burs after death. To the Funeral Diractor: After this certificate h completely filled in by the funeral director, page	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	il: 1 ☐ Inpatient 2 ☐ ER/Outpatie Date of Injury (Month, Day Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing H	ath (Check only one) Home 5 Residence (28d. Describe how injur	∰Other (Specific ry occurred	Hospice Home
Divis	al or Atta s after des it Diracto od in by th	Certification;	3 Suicide 6 Could not be determined 28e	p. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street an City or Town, State		al Route Number,
~	To the Höspital or Attan within 24 hours after deatl To the Funerat Diractor: completely filled in by the	edicai ((Check only 2 Medical Examiner: O	To the best of my knowledge, deat in the basis of examination and/or in ind manner stated.	th occurred at the time, date and place exestigation, in my opinion, death occurred	e, and due to the cause(s) urred at the time, date and	and manner as s i place, and due to	stated. the cause(s)
	withi Totl	Ň	29b. Signature and title of contine		29c. License number 0 6 4 1 2	18 29d. Dat	te signed (Month,	Day, Year)
	6		30. Name and address of person who complete Dr. Charles Harriso		Print) er Mill Road, Roc	kville, MD	20850	
	Sta Registr		31. Date filed (Month, Day, Year), APR 0 5 2004	32. legistrar's Signature	Spark			

			1 - For State Registrar		f Maryla	nd / Depa			ealth a	and M		Reg. N	71111	4	10262
	Physic	an	1. Decedent's Name (First, Middle								2. Date of D Month	D		ear .	3. Time of Death
	/Medi	cal	Lois Arlene	Shannon	-61		44. 63	_	. U.		March				0136 a™
	Exami	ıer	4a. Fecility Name (If not institution Shady Grove Ho	-	nber)				Location o	r Death		4	C. County of		
	Funeral		5. Social Security Number		7. Age (In yr	s. last birthday)	If Unde	ockv:	If Under 2		8. Date of Bi	rth	Monte		
	Director		362-20-8730	1 □ M XX F	79	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D Nov.			Coun	ace (State or Foreign try) SSOuri
	p ,		Usual Residence of Decedent		140							,			
	aryla ahov	_	MD Mont			City, Town or Lo	ocation							10	Od. Inside City Limits
	with the Maryland a or 28a-f ahow be notified at	Director	10e. Street and Number	tgomery	P	otomac	10f. Zir	. 0 - 1 -				10 0			1√2Yes 2□No
	with a or	2	9217 Willow Po	and I and				0854				_	itizen of Wha		•
	death w	Funeral	11. Marital Status	12. Was Dece	dent Ever in	U.S. 13.			spanic Orio	in? (Spe	cify Yes or No		nited		
9	or Ite	Ē	1 Never Married 2 Marr		2 X No	1				Puerto	ecify Yes or No Rican, etc.)		Black, \		
903	(2) ~ =	d by	3 XVidowed 4 □ Divorced	If Yes, Give Year or Da	e ates:		1 🗆 Yes	2 X X\\0	Specify:			İ	Specify:	wł	nite
5-(72 hour "natural"	ete	15. Deceden (Specify only higher	it's Education st grade completed)		16a. Dece	dent's Usu kind of wo	al Occupa	ition <i>Juring</i> most)	of worki	ng	16b. I	Kind of Busin	ess/Ind	Store/
121	withlr ene. than	Completed	Elementary/Secondary (0-12)	College (1-	-4or 5+)		es C])			W	oodard	and	1
Maryland 21215-0036	filled Hygir other	e Co	17. Father's Name (First, Middle,	Last)		Jai	.65 01	LEIK	18. Mother	's Name	(First, Middle	Maide		thro	op
<u>a</u>	ld be ental ked c	To B	Paul Stroyke								Chestn				
ary	shou and M s mar umat		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street a			l Route Numb		or Town, Sta	te, Zip (Code)
	and 2 salth i		Sandra L. Bowd	len/ Person	nal sentat	ive 1	9001	Swan	Driv	e, 0	aither	sbur	ce. MD	20	1879
ore	of He		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation	•	20b.	Place of Dispo cemetery, crer	sition (Nar	ne of			ate		ocation - City		
Ë	Pag ment tant:		* 4 ☐ Donation 5 ☐ Other (S		Me	ount St	. Mar	y's	Cem.	4/3	/04	Ea	ast Pro	ovid	lence, RI
Baltimore,	permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than any injury or other traumatic avent, ILen Once.		21. Signature of Funeral Service	License	11/10				s of Facility		1	1 0		0	
	002 60		23a. Penn. Enter the disease, or	AMUL	KU	VI	040 R	ockv	ille	Pike	ral an Rocky	$\frac{1}{111}$	ematic , MD	$\frac{208}{208}$	52
	Physician /Medical Examiner		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	or as a conse	Quence of):	15				i i espiratory a		···		Approximate Interval Between Onset and Death
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (c	ur as a sonse	LUN quenca of):	ζ	CAI	V LE	7					
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events												
oʻ	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (c	or as a conse	quence of):									
8760,	ate br	Ical		d											
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transitions.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknow		nth 2□Fet untattime of	el death 3 🗆	Ectopic pro				143		23d. Date of Month		y Day Year
O.	res that igned by be deta		Part II. Other significant condition	ns contributing to de	ath but not re	sulting in the ur	derlying ca	ause give	n in Part I.		23e. Did to	obacco	use contribut	e to the	cause of death?
Records,	v requires been sign should be	d by									101	res 2	₩ No 3[Probat	oly 4 Unknown
CO	aw requir s been si s should	Completed									24a. Was	an	24b. Were	autops	sy findings available
R	sician: The law s certificate has b lirector, page 2 s	E O		-							autop	sy rm ę d∂	prior death	to comp	oletion of cause of
Vital		Bec	25. Was case referred to medical						26. Place o	of Death	1 ☐ Yes (Check only o		1 1 1	es 2	No
of V	Physician: this certificatal director,	2	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 2 n	patient 2	ER/Outpatient	3 DO	Other			e 5 Resid		6 ☐Other (S	pecify)	
0	ding Pl h. After ti funera		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time of Injury	2	Bc. Injury Work			8d. Describe h				
sio	Attending or death. ector: After by the fune	catl	2 Accident investig	gation			М		es 2□No	0					
Division	I or At after of Direct in by	Certification;	4 Homicide determi	ined 286. Place of	of Injury - At h g, etc. <i>(Speci</i>	nome, farm, stre fy)	et, factory	, office		2	8f. Location (5 City or Tow	Street an m, State	nd Number or e)	Rural F	Route Number,
	To the Kospital or Attending Physician: whin 24 hours after deals are deals To tha Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier 1 Certifying (Check only one)	g Physician: To the base Examiner: On the base and manne	sis or examini	owledge, death ation and/or inv	occurred a	at the time in my opi	, date and nion, death	place, a	nd due to the o	cause(s)	and manner d place, and c	as stat	ed. ne cause(s)
10	To the within 2 To tha comple		29b. Signature and title of certifier				29c.	License	number			29d. Da	te signed (Mo	onth, Da	ny, Year)
	1		· hu	an Beco	1 m	10		00	057	1/2			111		
	10		30. Name and address of person v	who completed cause	of death (Ite	m 23a) (Type, F					t				
	1		Dr. P. Bao, 9					lockv	ille.	MD	2085	2			
8	Sta Registra		31. Date filed (Month, Day, Year) APR 0 5 2	32. Re	gistrar's Sign	ature &	-	M.							

			1 - For Stata Registrar		State o	of Maryl	and / De <i>C</i>	partme ertifica	ent of H ate of L	ealth D <i>eatl</i>	and M	lental Hy	/gien Rag. N	2004	10263
	Physici /Medic		1. Decedent's Name (First, Midd Albert A.	Schn	nidt							2. Date of D Month March	D	ay Year 2004	3. Time of Death 1:45p M
ı	Examin		4a. Facility Name (If not institution Fairhaven He			er		Sy	ty, Town, or kesvil	lle				c. County of Dea	uth
	Funeral Director		5. Social Security Number 473-07-4719	6. Sex	M 2□F	7. Age (In) 85	yrs. last birthda Yrs.	Month	der 1 Year is Days	If Unde Hours	Min.	8. Date of Bi (Month, D Apr 23	ay, Yea	r) C	thplace (State or Foreign ountry) √&
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Md. Carro			10c.	City, Town or Sykesy						-		10d. Inside City Limits 1 Xes 2 No
	death with the Maryland me 23e or 28e-f show Finast ke rediffed at	ai Director	10e. Street and Number 7200 Third A	venue	<u> </u>			1	Zip Code 21784				_	Citizen of What C	ountry?
	72 hours after death with the Manylan natural; or iteme 23e or 28e-1 show deat Examinet ment to redified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☒ Widowed 4 □ Divorced	ned	Armed Fo	2 □ No 1			cedent of Hipecify Cubar	spanic C n, Mexica Specifi		ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Whi Specify: W	te, etc.
1215-0036	within 72 hou iene. then "natura i e Modicia	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Educa	tion completed) College (16a. De (Gi	ve kind of DO NO	sual Occupa work done d use retired; cal ma	luring mo)		ing		Kind of Business	/industry
land 2	be filed tal Hygi d other event,	To Be Co	17. Father's Name (First, Middle, Gerhardt Schm	,						18. Moth	her's Name	e (First, Middle	, Maide	en Sumame)	
, mary	1 and 2 should Health and Men tem 27 ie marke	-	19a. Informant's Name/Relations Gary D. Schmidt											or Town, State, , Md 217	
aitimore,	permit. Pages 1 and Department of Healt Importent: if Item 2 eny injury or other 900.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (5	Specify)		State	b. Place of Dis cemetery, c 1.1 Coun	rematory c ty Ci	rotherplace emati	on	4-2-0	Date)4		Location - City or $esville$,	
Bail	Departi Departi Importi eny in		21. Signature of Funeral Service	C try	ferbo		P	.0. I		5 Sy	kesv	ille, M	ld 2.	al Home 1784	& Chapel
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. b.	Due to	(or as a con	sequence of):	enter the m	ode of dying	, such a	s cardiac o	er respiratory a	D.	/ ·€~\\\ 1°	Approximate Interval Between Onset and Death
28760,	ficate be executed g physician and is the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	Due to	(or as a con	sequence of);								
O. Box	ath certi ttending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	230	1 Live t	tcome of pre pirth 2 F nant at time own	etal death	B⊟Ectopic B⊟ Other	pregnancy (specify)					23d. Date of de Month	livery Day Year
ords, P	w requires that the de been signed by the a should be detached t	δ	Part II. Other significant condition	ons contri	buting to d	eath but not	resulting in the	underlying	g cause give	n in Part	1.	1	tobacco Yes 2		o the cause of death?
Vital Records,		Completed												prior to death?	utopsy findings available completion of cause of 2 No
OT VIT	Physicien: r this certific ral director,	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	-			2 ☐ ER/Outpat	ient 3		r. 4 🖳		n <i>(Check only i</i> me 5 ☐ Resi		6 □Other (Spe	cify)
DIVISION C	anding lath. or: Afte	Certification:	27. Manner of Death 1 Natural 5 Pendii 2 Accident invest 3 Suicide 6 Could	gation		th, Day Yea		M		at ? 'es 2 []No	28d. Describe			-
<u>∑</u>	or A		4 Homicide determ	nined	buildi	ing, etc. (Sp						City or To	wn, Stat	te)	ural Route Number,
V	To the Hospitei within 24 hours a To the Funerei i completely filled	ledical	one)	Examine	r: On the b	asis of exam	nination and/or	investigati	on, in my op	inion, de	ath occurr	and due to the ed at the time,	date an	s) and manner as nd place, and due	to the cause(s)
	with Con	W	29b. Signature and title of certific	1.	M	723.	me		9c. License	35	PZ		~	ate signed (Mont	
1)		30. Name and address of person	6.	M	011	1/7	e, Print)	Zin-	t,	6.	1.	10-	. Rei.	for four
	Sta Registr		31. Date filed (Month, Day, Year	200	4 32. F	ledistrar's Si	onsture	1	park						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year Dorothea Shew April 2004 5:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Middle Kiver

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Country) | 1. Aug. | 19,1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 1927 | 7219 Greenbank Rd. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🛛 F Director 215 22 0060 76 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 77 is marked other then "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at Maryland Baltimore Middle River 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7219 Greenbank Rd. 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within and Mental Hygiene. Maryland Elementary/Secondary (0-12) College (1-4or 5+) Operations Specialist 12 Casualty Company 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental F William Baker Rennie Catherine Agnes Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 tr of Health a : If item 27 is Evelyn B. Shew (Daughter) 7219 Greenbank Rd. Baltimore, Md. 21220 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of h 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If eny injury or -6-04 Holly Hill Mem. Gardens 4 * 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Lice is 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 Pat1. Enter the disease, or complications that cause lock, or heart failure. List only one cause on each d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 le la S 10 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. sicien Physician/Medicai the phys IF FEMALE for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. the i detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 2 autopsy performed? 1☐ Yes 2█ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 ☐ Yes 2 X No 2 1 Inpatient 2 ER/Outpatient 3 DOA PIS funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of After 1 28c. Injury at Work? Certification: 28d. Describe how injury occurred the Hospital or Attending 1 XNatural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) þ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after filled in the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 2 29c. License number 20649 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John W. Bowie M.D. 6701 N. Charles St. Baltimore, Md. 31. Date filed (Month Day, Year) APR 0 5 2004 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 0.01

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Section of Code 19 Section of Co	3			Russell	Wayne	Sa	wyer		APRIL	_ B, 201	54 2:30Am
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Directory Committee Commi	18.			Stella Maris	at Mercy H	Hospital					
The State of North St	3		O	217 64 4193		· ·	Months I		8. Date of Bird (Month, Da Dec. 1	y, <i>Year)</i> , 1955 Ba	
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Physician Medical Examiner Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	S		100	10-12		abordooth Do	1407 O	ld Eastern A	Avenue I	Essex Mary	
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Podistrar Piet (1 t) (1814 April 10 Estate Section 10			State Registrar	31. Date filed (Month, Day, Year) APR 0 5 2004	32. Registra	ar's Signature	Look.	A.			

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SHANNON 30A N **Physician** ERNESTINE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner **BALTIMORE** BALTIMORE COUNTY NORTHWEST HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) NOV. 7, 1915 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M XXF 88 215~09~8790 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State rai', or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2/CXNo Director Baltimore Baltimore County Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 USA 124 Linhigh Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 🏋 No Specify: White Baltimore, Maryland 21215-0036 3√XWidowed 4 □ Divorced Year or Dates: "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) n 27 is marked other than "v traumatic even" Elementary/Secondary (0-12) College (1-4or 5+) Shell Oil Company 12 yrs. <u>Bookkeeper</u> 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be August F. Koehler Rosie Schlesinger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2815 Putty Hill Avenue Baltimore, Maryland 21234 item 27 I other tra Ruth Gilland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a Method of Disposition permit. Pages Department of I Important: If it any Injury or o once. XX Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 4~5~2004 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassann Funeral Home 21. Signature of Funeral Service Licensee 0.7. 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last pue Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 moons? 3 Ectopic pregnancy Day Month 5 Other (specify) Yes 2 10 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 86 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred in by the funeral Alter Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier, to completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso NWHE 01 31. Date filed (Month) 32. Registrar's Signature State Registrar

	•	For State Registrar	State of Maryla		artment of H		d Mental H	ygiene Reg. No		10267
Physicia /Medica	n	1. Decedent's Name (First, Middle, Last) Ethel A. Thomps	son				2. Date of D Month March	30°		3. Time of Death 11:10 pm M
Examine	er	4a. Facility Name (If not institution, give s 7610 Boulder Drive 5. Social Security Number 6. Sex	2	. last birthday)	4b. City, Town, or Sykes	ville			Carrol	1
Funeral Director			M 2 T 84	Yrs.	Months Days		drs. 8. Date of B (Month, 2 Apr 5	1919	9 5	thplace (State or Foreign ountry) MD
death with the Maryland ms 23s or 28s-f show return be rediffed at	ctor	10a. State 10b. County MD Carrol1	İ	ity, Town or Lo	Sykesvill	e				10d. Inside City Limits 1 Yes 2 □ No
23a or 24	rai Director	10e. Street and Number 7610 Boulder Driv			10f. Zip Code 217				USA	
urs after al', or ite	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Xwidowed 4 Divorced	12. Was Decedent Ever in \(\) Armed Forces? 1 \(\) Yes 2 \(\) You If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nierto Rican, etc.)	lo-	14. Race - Am Black, Whi Specify: W	
within 72 ho iene. then *natur i'e Medical	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup a kind of work done o DO NOT use retired Memaker	ation during most of	working	16b. K	ind of Business Domes	
be filed htal Hyg ed othe event,	To Be Co	17. Father's Name (First, Middle, Last) Louis Walker					Name (First, Middle Ssie Hung			
ss 1 and 2 should of Health and Men item 27 ie marke other traumatic	- 1	19a. Informant's Name/Relationship (Ty) Mr. Thomas Thompson	n (Son)	7610	Boulder		ykesvill	e, MI	21784	
permit. Pages 1 Department of He Important: If iten eny injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cre pringf	osition (Name of matory or other place ield Ceme	tery 4	Date 4/3/2004	Sy	ykesvil	le, MD
permit. Depart Import eny inj		21. Signature of Funeral Service License	. Haight		HAIGHT F Sykesvill				PA (B	
Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the decline cause on each line. Dyon Ch Due to (or as a conse		ter the mode of dyin	Lmq	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
executed on and rial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfug Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse							
death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 To 0 9 Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pregnancy □ Other (specify) _	1			23d. Date of de Month	livery Day Year
es the	ρ	Part II. Other significant conditions cor	htributing to death but not re	sulting in the t	underlying cause giv	en in Part I.				o the cause of death? robably 4 □Unknowr
	Completed						24a. Wa aut per 1 🗆 Yes	opsy formed?	death?	utopsy findings available completion of cause of s 2 No
ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	la anitali		Oth		Death (Check only			
Physic this c al dire	2	1 Tes Solvio		ER/Outpatie			g Home 5 Re			ecify)
Attending Per death. ector: After I by the funera	ertification:	27. Manner of eath 1	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	y at k? Yes 2 □ No	28d. Describe			
tel or Att rs after d el Direct led in by 1	Certifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		treet, factory, office		28f. Location City or T	(Street an own, State	nd Number or R	tural Route Number,
Lo the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the tuneral director.	edicai		sician: To the best of my kiner: On the basis of examinand manner stated.		nvestigation, in my o	pinion, death o		e, date and	d place, and du	e to the cause(s)
	Σ	29b. Signature and title of certifier	Cuy Hash		29c. Licens	3443		31	31164	
:4		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type	Print) BIVel	west	minster	1 MJ	0 211	57
Sta	te	31. Date filed APR D 5ar 2004	32. Pegistra Sig	nature	Sparks	/				

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 8:00 **Physician** 2004 0151 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner tone Ohn! If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (in yrs. last birthday 5. Social Security Number Days Months Hours **Funeral** 1 ☐ M 2 🔀 F Nov. 10,1965 Maryland 220 88 7668 38 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.
Item 27 is marked other than "naturel", or Iteme 23a or 28e-f ahow other traumatic event, the Marylam Examinating that notified at 1 ☐ Yes 2 XNo Joppa Harford Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21085 2607 Green Spring Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 X Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☒ No Specify: Maryland 21215-0036 þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Disabled 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Regina Kathryn Gomeringer Walter Joseph Verbus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2607 Green Spring Ave. Joppa, Md. 21085 Walter Joseph Verbus (Father) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 0 = 0 1 Burial 2 Tremation 3 Removal from State 4/5/2004 Baltimore, Maryland permit. Page Department of Important: If any injury or pnce. Bayview Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, 21. Signature of Funeral Service Licensee 21221 Md. Approximate Interval Between Onset and Death 23a Pf.11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) IWEEK Adult RESPIRATORY Physician /Medical Que to (or as a consequence of): Examiner NUMBORA france in the state of the stat Due to (or as a consequence of). COULED TOMUSCHEFICIENCY SYNDROME
Due to (or as a consequence of): Examiner The law requires that the death certificate be executed HECHICED use as the burial-tran physician Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No 5 Other (specify) P.0. detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate has 1 Yes 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No this 28a. Date of fnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury at Work? 27. Manner of Death Alter Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide in by t 4 Homicide filled the Hospital within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 RES-DOC MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. WOLFE StepEt HORKIAS HOSPITA John 32. Registrar's Signature State Registrar

Registrar

WILLIAMS

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year <u>10:2</u>2^{а м} **Physician** 3 31 2004 Annie Ρ. Wallace /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner N/A Balto 3802 Bowers Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1□M 2ĀF 66 N.C. Director 244-52-6262 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show 10a. State 10b. County X☐Yes 2☐No Director N/ABalto Μd the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or Items 23a or the Medical Exponent must be 3802 Bowers Avenue 21207 USA death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify Black 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: þ 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Clifton T. Perkins Elementary/Secondary (0-12) Coltege (1-4or 5+) 12th grade LPN years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) nt of Health and Mental H: If Item 27 Is marked off Be Calvin Sinclair Annie Huggans 2 19a. Informant's Name/Relationship (Type, Print) -Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 21207 3802 Bowers Avenue Balto, Rowena Denise Wallace 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Garrison Forest Vet 4-6-2004 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Md 21215 Wabash Avenue Balto. 4300 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hepatic ence
Due to (er as a consequence of): 1 month encephalogattu **Physician** /Medical **Examiner** Live cirrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Panaytopema burial-tran Due to (or a co sequence of): P.O. Box 68760 TENSION Physician/Medical tF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown ∮ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, Alcoholism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 **X**No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check on one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 tilled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 5 Pending investigation 1 KNatural 1 ☐ Yes 2 ☐ No death. 2 Accident thours after death uneral Director: 6 Could not be determined 28e. Place of tniury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Hunsizian MD D0056950 who completed cause of death (Item 23a) (Type, Print) Frace Branch Road, 6/en Pannie MO 21060 Agajelu 7445 East 32. Registrar's Signature State Registrar

			State of Maryland / Department of Health State Certificate of Deat	n and Me th		giene ()	0 ل	10271
		T).	Decedent's Name (First, Middle, Last)	1	2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medio		Frank Anthony Yapps, Jr.		April	1, 20	004	2130 M
	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location 4b. City, Town, or Location 4c. City,	on of Death		4c. County	ford ford	
		*	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	der 24 Hrs.	B. Date of Bin	th	9. Birtho	place (State or Foreign
	Funeral Director		145-36-3872 1XM 2 F 59 Yrs. Months Days Hour	rs Min.	sept. 2	y, Year) 3, 1944	New	Tersey
	pu 💃		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				1	0d. Inside City Limits
	ahov	ö						1 ☐ Yes 2 ☑ No
	the N 28a-1	Director	Maryland Harford Joppa 108. Street and Number 107. Zip Code			10g. Citizen of	Nhat Cour	ntry?
	death with the Maryland ms 23e or 28a-f show Frutst be rictified at	al Di	1204 Jomat Drive 2108	85		u.s	.A.	
	ems a	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic If Yes, specify Cuban, Mexic	Origin? (Specican, Puerto R	ify Yes or No ican, etc.))- 14. Rad Blad	e - Americ ck, White,	ean Indian, etc.
36	s afte	by Funeral	1 ☐ Never Married 200 Married 1 ☐ Yes 200 No If Yes, Give 1 ☐ Yes 200 No Spect Year or Dates:	city:		Specify	r:Whit	te
2130	be filed within 72 hours after death with the Marylar tall Hygiene. Id other than "naturel; or items 23e or 28a-f show event, the Medical Exercities may be notified at	ted t	15. Decedent's Education 16a. Decedent's Usual Occupation			16b. Kind of B	usiness/In	dustry
5/	thin 72	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during milde. DO NOT use retired)			Baltim		
	ygien ygien ft. Ing	Con	4 Physical Education			Public Maiden Suman		ols
Maryland	an y all of the filed within and Mental Hygiene. Is marked other than aumatic event, the Mental Aumatic event, the Mental aumatic event, the Mental Aumatic event.	Be	, , , , , , , , , , , , , , , , , , , ,	dna Ma			10/	
2	should ind Men marke umaric	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num				State, Zip	Code)
	and 2.		Mrs. Teresa Yapps (wife) 1204 Jomat Drive	e, Jopk	oa, MD	21085		
4/1/04	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Da		20c. Location -		
	Pages tment of tent: If its jury or o		'4 Donation 5 DOther (Specify) Highview Mem'l Gard.					
7	permit. Pages 1 and 2 should bepartment of Health and Men Importent: If item 27 is marke any injury or other traumatic.		21. Signature of Funeral Service Licensee 22. Name and Address of Fa 9705 Belair					
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	as cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	2007	telle			Orisot and Doam
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions.	,)		
	\$1,274	ē	if any leading to immediate Due to (or as a consequence 1):	chen				
9180	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c. dulleles					
6	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):					
4109	cate b	dlca	d					
# X	box of any of an	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		-	23d Da	te of delive	any
A >0	death death d for u	iclar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)				onth	Day Year
	that the de ed by the detached	hysi	9 ☐ Unknown					
4	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Completed by Physician/Medical	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I.		obacco use cont Yes 2 □ No	ribute to th	ne cause of death?
Thony	aw red	olete	rente la land		24a. Was	an 24b.	Were auto	psy findings available mpletion of cause of
7 0	The It	lmo			autor perfo	ormed?	death?	No No
An }	ysicien: Th ysicien: Th is certificate director, pag	BeC	eyaminer?	lace of Death				
7	- 8 S	မ				dence 6 Oth		y)
Fa	ding Ph h. After th funeral	tlon	1 Natural 5 Pending (Month, Day Year) Injury Work?		su. Describe	now injury occur	eu	
10	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28	Bf. Location (Street and Numb	er or Rura	al Route Number,
و ا	5 4 4 5 E	Certi	4 ☐ Homicide deletimined building, etc. (Specify)		City or To	wn, State)		
1/2	e Hospitel 24 hours a e Funerel (letely filled	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, of and manner stated.					
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier 29c. License number	eer		29d. Date signe	d (Month,	Day, Year)
	1		Dews 5. Du 0322	93		April	2,	2004
	19		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVYD 5. DVN L, TWA-PNA,	1 B	0/0,0	mo		
	St Regist	ate rar	31. Date filed (Month, Day, Year) 2004 32. Registrar's Signature & Society					

			For State Registrar	State of Ma	ryland / Depa	artment of F			ene g. No 2004	10272
			Decedent's Name (First, Middle, Landson L	ast)				2. Date of Death	9.1107-	3. Time of Death
	Physicia		CHARLES	LEROY	ZIEGL	ER JR		APRIL	Day Year 2006	1 1250 M
}	/Medic Examin		4a. Facility Name (If not institution, gi				or Location of Death		4c. County of Deat	
	LAGIIIII		Washington Co	unty Hosp	ital	Hager	stown		Washing	aton
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)			8. Date of Birth (Month, Day, August 1		hplace (State or Foreign
	Director		214-09-9898	X □M 2□F	88 Yrs.	Worth's Days	Tiodis Willi.	August 1	11,1915 Ma	aryland
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ecation				10d. Inside City Limits
	aho	or.		ington	Hagers					1 □ Yes 2√□ No
	the N	ect	10e. Street and Number	Lington	Hugera	10f. Zip Code		10	g. Citizen of What Co	
	with	Ω	1230 Frederic	k Street		2174	n		U.S.A.	,
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f ahow ra Najical Exarili eri suat be molified at	Funeral Directo	11. Marital Status	12. Was Decedent E	ver in U.S. 13.		dispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	nican Indian,
(0	r Itar	Fun	1 Never Married 2 Married	Armed Forces?	0	_		Rican, etc.)	Black, Whit	e, etc.
036	al', o		3 ☐ Widowed 4 X Divorced	If Yes, Give 19 Year or Dates	41–1945	1□ Yes 2☑ No	Specify:		Specify: W	<i>l</i> hite
21215-0036	72 ho	Completed by	15. Decedent's E (Specify only highest g		16a. Dece	dent's Usual Occup	pation during most of worki	na 1	6b. Kind of Business/	Industry
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+	F)		during most of worki		State Pris	on System
	led w lygier her th	ပ်		2	Supe	rvisor	of Educa	101011		on System
and	be fi	Be	17. Father's Name (First, Middle, Las		7:1	0	_		,	
Z Z	2 should be f and Mental F la marked of aumatic avai	2	Charles 19a. Informant's Name/Relationship		Ziegler	Sr.	Jessie		ace Ba	arkdoll
Maryland	d 2 sith and the and traum		Susanne D. Zi						tle, WA. 9	
	1 an Heal tam 2		20a. Method of Disposition	-9	20b. Place of Dispo				Oc. Location - City or	
<u>ا</u>	Pages nent of I int: If its iry or o		1 ☐ Burial 2 X Cremation 3		Smithsburg		' 04	05-04 S	mithsburg,	Marvland
Baltimore,	그 문문 등		21. Signature of Funeral Service Lies		25	Name and Addre	es of Facility			
Ö	Depa Impo any ii		R. hoel B.	eady	A1	narew K. D E. Anti	Collman F etam Stre	unera⊥ H et. Haαe	ome, Inc. rstown, Mo	1. 21740
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused to	the death. Do not ent	er the mode of dyir	ng, such as cardiac o	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Conta	Jesn1/6	> HeA	RT FA	Line		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):			1.01		
	Cxammer	_	Sequentially list conditions,	b. PNec	MONIE	F				
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	xecut and al-trar	xan	that initiated events resulting in death) Last	cDue to (or as a	consequence of):					
8760	The law requires that the death certificate be executed at the been signed by the attending physician and bage 2 should be detached for use as the burial transit									
687	ficate p physis the	Physician/Medical		d						
Вох	eath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Te			23d. Date of del	ivery
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at t		Ectopic pregnancy Other (specify)	y 		Month	Day Year
0	t the by the	hys	9 🗆 Unknown	9 Unknown				A		
S,	res that the de signed by the a be detached t	ру Р	Part II. Other significant conditions	contributing to death but	t not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ğ	w require been signshould t							1 ☐ Yes	s 2 No 3 Pr	obably 4 Unknown
Records,	e faw r has be je 2 sh	Completed						24a. Was an autopsy	prior to d	topsy findings available completion of cause of
		Соп						perform 1 ☐ Yes 2	ed? death?	
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		0.1	26. Place of Death	(Check only one)	
of	Physic this caldir	10	1 ☐ Yes 2 No 27, Manger of Death	28a. Date of Injury			4 Nursing Ho	me 5 Resider	nce 6 Other (Spec	cify)
nc U	ding Physician: The n. After this certificate hit funeral director, page	lon	Natural 5 ☐ Pending	(Month, Day	Year) Injury	Wor	rk? Yes 2 □ No	zad. Describe nov	w injury occurred	
Division	Attanding Physician: r death. actor: After this certifici by the funeral director, I	lical	3 Suicide 6 Could not	be 300 Place of lain	ry - At home, farm, str			28f. Location (Stre	eet and Number or Ru	ıral Route Number.
Div	after after Dira d in b	Certification:	4 Homicide	building, etc.	(Specify)			City or Town,	State)	
	To the Hospital or Attank within 24 hours after deatl To tha Funaral Diractor: completely filled in by the		29a. Certifier 1 Certifying F	hysician: To the best of	f my knowledge, death	n occurred at the tir	me, date and place,	and due to the car	use(s) and manner as	stated.
	he Ho in 24 ha Fu pletel	edical	(Check only 2 Medical Exa	miner: On the basis of and manner stat	examination and/or in	vestigation, in my o	opinion, death occurr	ed at the time, da	te and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. Licens	i		d. Date signed (Monti	h, Day, Year)
	=	<	and the same of th	1111		20	75794	7	1/4/04	
	Q		30. Name and address of person who	completed cause of de		Print)	as Du	4.1-	ithoersa	am has
	Ch	to	31. Date filed (Month, Day, Year)	₹32. Registra	S relative	TC Utri	us Dh	1745		
	Sta Registi		APR 0 5 200	4		W				
			L		7					

		·	1 - For State Registrar	State of Mary	land / De	partme		ealth and		giene Reg. No	_	14 1027
1	nysicia Medic xamin	ai	1. Decedent's Name (First, Middle, Last) GEORGE E. ABBOT 4a. Facility Name (If not institution, give s Saint Joseph N	treet and number)	enter	4b. Ci	y, Town, or	Location of De		IL Da	County of De	24 10:20 PM
	neral ector) = 1 	5. Social Security Number 6. Sex 212-14-2040	7. Age (In	yrs. last birthda Yrs.	Month	er 1 Year s Days	If Under 24 H Hours M		rth ay, Year,	9. E M	Birthplace (State or Foreign
OUCOO hours after death with the Maryland ural: or Items 23a or 28a-f ahow	Examiner must be notified at	Funeral Director	10a. State 10b. County MD BALTIMOR 10a. Street and Number 8722 LACKAWANNA A	RE	c. City, Town or	PAR 10f. 2	pedent of His pecify Cubar	1234 spanic Origin? n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	U	Black, W	merican Indian, hite, etc.
VIGILIO & L. E. 13-10030 vuld be filed within 72 hours aff Mental Hygiene.	event, the Mudical	To Be Completed by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th GRADE 17. Father's Name (First, Middle, Last) GEORGE E. ABBOTT,	Year or Dates: eation completed) College (1-4or 5+)	16a. Dec	cedent's Usive kind of the DO NOT	AL SU	tion uring most of v	R lame (First, Middle	ST	and of Busine	WHITE ss/Industry MARYLAND
of Health and I from 27 Is my	ury or other treum		ANNA G. ABBOTT / WI 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □R. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	FE 2	872. Ob. Place of Dis Commeter V. C DULANEY	2 LAC position (^ remajory o VALL	KAWANI lame of rother place EY M.	NA AVEN	Rural Route Numb UE BALTO Date 6/04 HE JOHNSO	20c. L COC	MD 2123 ocation City KEYSVII	
- <u>-</u> - ×	dical hiner	licai Examiner	23a, Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the e cause on each line. FULMONAR Due to (or as a co CORONAR) Due to (or as a co RENAL FA Due to (or as a co	death. Do not early EDEN nsequence of): ARTEN nsequence of): AILURE nsequence of):	PART D	ode of dying	, such as card	LVD. TOWS	irrest,		Approximate Interval Between Onset and Death
. 0 0	detached for use as the buria	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetel death	3 □Ectopic 5 □ Other (23d. Date of o Month	lelivery Day Year
law requires that the as been signed by th			Part II. Other significant conditions con ABDOMINAL AORTIC A		ot resulting in the	underlying	cause give	n in Part I.	23e. Did t			to the cause of death? Probably 4 □Unknown
The law ate has b	page 2	e Completed	CAROTID ARTERY STE	NOSIS					1 Tes	psy ormed? 2 No	death	autopsy findings available o completion of cause of ? es 2 \(\text{No} \)
ng Phys	the funeral du	Certification: To Be	examiner?	28a. Date of Injury (Month, Day Ye	At home, farm,	of M	28c. Injury Work 1 Y	4 🗆 Nursing	eath (Check only of Home 5 Resilies 28d. Describe 28d. Location (City or To)	dence how inju	ry occurred	pecify) Rural Route Number,
Hospitel 4 hours Funerel	ely fil	edical Cert	29a. Certifier 12 Certifying Phys	ician: To the best of me er: On the basis of exa and manner stated.	y knowledge, de	ath occurre	ed at the time on, in my opi	e, date and pla inion, death oc	ce, and due to the	cause(s	and manner	as stated. ue to the cause(s)
To the within 2	Compl	Me	29b. Signature and title of certifier 30. Name and address of person who con	mg	(Item 23a) (Typ		9c. License D 25	number 886		29d. Da	te signed (Mo	nth, Day, Year) 4 - 200 4
R	ال Stat egistra	_	31. Date filed (Month, Day, Year)	M. D. 762		R DF	RIVE,	TOWSC	IN, MARY	<u>LAN</u>	D 212	Ø4

DHMH 17 Rev 1/2001

ORIGINAL

		,	For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of F rtificate of	lealth and M Death	lental Hyg	iene 200	4 10271
€,	Physici /Medic	2.	1. Decedent's Name (First, Middle, Las Ida Brown	st)				2. Date of Death Month Moych	h Day Year 30 2004	3. Time of Death 2:04 A M
	Examin Funeral Director		4a. Facility Name (If not institution, give UMVEVSity of May 5. Social Security Number 6.5.	land	last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct 26,	Year) Ca	th thplace (State or Foreign punity) aryland
	yland		Usual Residence of Decedent 10a. State 10b. County MD		y, Town or Lo					10d. Inside City Limits
	r 28a-f si	Funeral Director	10e. Street and Number	1	Baltim	10f. Zip Code		110	0g. Citizen of What Co	1∭Yes 2☐No ountry?
	23a o	raiD	1125 N. Carey St				1217		USA	
036	72 hours after death with the Maryland natural; or items 23s or 28s-f show diest Exactiver ment be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ሺ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: b1	te, etc.
21215-0036	within ane. than	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	Jucation de completed) College (1-4or 5+)	16a. Dece (Give life.		ation during most of work	ing	16b. Kind of Business educat	
g	ould be fited wented Hygie Mented Other arked other attice event, III	Be	17. Father's Name (First, Middle, Last) James Chester				18. Mother's Name			1011
ary	should and Me s mark umatic	٦ ا	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street			City or Town, State,	Zip Code)
Š.	l and 2 lealth a lm 27 is		Ida Moore/mother	20h B	112	5 N. Care	y Street		re MD 21	
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e ODG:		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify	y)		osition (Name of matory or other plac		Julio	eoc. Eocation - Oily of	Town, State
Bail	Depart Import any in		21. Signature of Funeral Service Licentee Service Licente	Wade irector	: St	2. Name and Addre tate Anat altimore,	omy Board	655 W.	Baltimore	Street
68760,	Physician and // Medical Examiner pural-transit	dical Examiner	23a. Part. Enter the disease or common shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	ng-eal wence of):	ter the mode of dyir		or respiratory arre	st,	Approximate Interval Between Onset and Death
P.O. Box 687	The law requires that the death certificate the has been signed by the attending phy age 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Date of de Month	livery Day Year
	w requires that s been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.		acco use contribute to	o the cause of death?
Division of Vital Records,		Completed						24a. Was ar autops perform 1 Yes 2	y prior to	utopsy findings available completion of cause of
VIII.	ysician: The scentificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 All patient 2	ER/Outpatier	nt 3□ DOA Oth	26. Place of Deatler: 4 □ Nursing Ho	211 A-1-01-01	e) nce 6 □Other (Spe	cify)
ion of	ding Ph h. After th funeral	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dale of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Wor		28d. Describe ho		,
Divis	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined		ome, farm, st	reet, factory, office		28f. Location (Sti City or Town	reet and Number or Ri , State)	ural Route Number,
	ne Hospita 24 hours ne Funera detely fille	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam one)	nysicien: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the tin evestigation, in my o	ne, date and place, pinion, death occurr	and due to the cared at the time, da	use(s) and manner as	s stated. to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifies	1 -110		29c. Licens			d. Date signed (Mont	,
,			30. Name and address of person who	completed cause of death (Iter	n 23a) (Tune	Drint	127		larch 30,	2004
			Darryn Pofosky	22 South	Green	ne Street	Baltim	ore Man	yland 21.	201
	Sta Regist		31. Date Ged (Month, Day, Year) APR 0 6 20	32. Registrar's Signa	d d	Sport	Baltim			

		•	For State Registrar	State of Marylan	-	artment of He			ene g. No. 200	4 10275
	Physici /Medic		1. Decedent's Name (First, Middle, La	M. BROWN				2. Date of Death Month MARCH		
	Examin		4a. Fecility Name (If not institution, give HOWARD COWUT	4 GENERAL		4b. City, Town, or Li COLUMB	(1)		4c. County of De	RD
	Funeral Director		5. Social Security Number 6. S 243.36.0058 Usual Residence of Decedent	7. Age (In yrs. I	ast birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. B	irthplace (State or Foreign Country)
	Maryland a-f show	ctor	10a. State 10b. County MO HOWA		, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 💆 No
	ath with the 23a or 28 ust Le no	Funeral Director	10e. Street and Number 10105 DARLINGT			10f. Zip Code 21044	}		g. Citizen of What C	
36	n 72 hours after death with the Marylan "netural", or items 23a or 28a-f show olicul Extraclinate by notified at	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hisp f Yes, specify Cuban, I □ Yes 2 IFNo	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	
215-0		Completed	15. Decedent's E (Specify only highest gra	ade completed) Collegej(1-4or 5+)	(Give life. I	dent's Usual Occupation kind of work done durage NOT use retired)	on ring most of worki	ng	6b. Kind of Busines	•
Maryland 21215-0036	ed la pe	Be	17. Father's Name (First, Middle, Last, DAN THOMPSON	NA	SUPE			(First, Middle, M		Crub
	s 1 and 2 should be if Health and Mental itam 27 is marked oothar traumatic eva	၉	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street and	d Number or Rura		•	Zip Code)
Baltimore,	Pages 1 and 3 nent of Health int: If itam 27 iry or othar tra		20a. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other (Specification)	Removal from State	lace of Dispo emetery, cren	sition (Name of natory or other place)		ate 2	Oc. Location - City of	
Balti	permit. Pages 'Department of H Important: If its any injury or of		21. Signature of Funeral Service Licel	T_		Name and Address USHN C G	NATU PIL	E BAL	10. mo	21228
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	Ren	1 =	Such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner	er	Securitarily list evolutions	Due to (or as a consequence SEPT) Due to (or as a consequence service)	CEMI	'A				Two weeks
o,	cate be executed oblysician and the burial-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. MULTIPL Due to (or as a consequ	uence of):	BCUBÎTI				Months.
κ 68760,	artificate be ing physici e as the bu	Medical	IF FEMALE:	d. URINAR		RACT 11	NFRCT	,0h		ONE WEEK
P.O. Box	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3□	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
	w requires that been signed b should be deta	ed by PI	Part II. Other significent conditions of	contributing to death but not resured out Dio	0 4	Mellitus	in Part I.	23e. Did toba		to the cause of death? Probably 4 Dunknown
Vital Records,	The law re ate has be page 2 sho	Completed by	Rheumatord	ARTHRITI	د'			24a. Was an autopsy perform 1 ☐ Yes 2	prior to	
Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:		Other		(Check only one		
of	nding Phys ith. :: After this e e funeral dir	ation: To	1 Yes 2 No 27. Manprer of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?	t Nursing Hol	ne 5 ☐ Residen 28d. Describe hov	ce 6 □Other (Sp v injury occurred	ecity)
Division	To the Hospital or Attanding F within 24 hours after death. To the Funaral Director: After completely filled in by the funer.	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
	the Hospi in 24 hou the Funar	Medical	(Check only 2 Medicel Exer	nysicien: To the best of my knominer: On the basis of examination and manner stated.	wledge, death tion and/or in	estigation, in my opin	nion, death occurr	ed at the time, dat	e and place, and du	ue to the cause(s)
) .	With Com	2	29b. Signature and title of certifier	Clarking			30469	A	V -	In. 2004
	10		30. Name and address of person who N B VELL ANK			Print) OF PR	ive, #1	119, 00	いてから	aty MD. 21042
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 6 2004	32. Registrar's Signa	Lo	actor &				

			Please I			partment of h			_	
			1 - For State Registrar	State of Ma		ertificate of			g. No. 200	10276
			Decedent's Name (First, Middle, Last)				20417	2. Date of Death		3. Time of Death
	Physici /Medi		Ronald Keith Bi	skup, Sr.				April	2 2004	2018 M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Deat	1	4c. County of Dea	ith
			Upper Chesapeake 5. Social Security Number 6. Secur		enter (In yrs. last birthd	Bel A		R Date of Birth	Harfo	
	Funeral Director			M 2□F	67	Months Days	Hours Min.	(Month, Day,	Year) 9. Bii	thplace (State or Foreign ountry)
			Usual Residence of Decedent					June 25	, 1930 Pe.	nnsylvania
	arylan show	2	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits 1 ☐ Yes 2 ☑No
r.	ith the Marylan or 28a-f show	Director	Maryland Harford 10e. Street and Number		Bel A	ir 10f. Zip Code		10	g. Citizen of What C	
d.	after death with the Maryland after tems 23a or 28a-f show minet must be notitied at		2323 Edwards Lar	10		2101	5	10,	USA	outiny :
00	death	Funeral		12. Was Decedent E Armed Forces?	ver in U.S. 1	3. Was Decedent of H If Yes, specify Cubi		pecify Yes or No-	14. Race - Am	
7.8	or its	y Fu	1 ☐ Never Married 2 ☑ Married	1 Ves 2 N	0	1 ☐ Yes 2 ☑ No	Specify:	o rican, etc.)	Black, Whi	te, etc.
$S_{\mathcal{O}_{\mathcal{C}}}$	within 72 hours after death w mins. Then "natural", or Items 23a the Medical Examinar must b	ed by	3 Widowed 4 Divorced	Year or Dates: 1	959-61	cedent's Usual Occup			6b. Kind of Business	White
/ Dr.	n na	Completed	(Specify only highest grade	e completed)	(G	ive kind of work done o. DO NOT use retired	during most of wor	king	ob. Kind of business	vindustry
24.5	d with giene	mo.	Elementary/Secondary (0-12)	College (1-4 <i>o</i> r 5-	1	xicologist			Federal G	overnment
2	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma	aiden Sumame)	
2	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Manatic event, the Mana	은		skup			Eleano		Smallwood	
Maryland 21	d 2 st th and t7 is r		19a. Informant's Name/Relationship (Ty) Carol B. Biskup			Alling Address (Street				Zip Code)
	Hear Hear		20a. Method of Disposition	MTTE	20b. Place of Di	3 Edwards sposition (Name of trematory or other place	rane Be		21015 Oc. Location - City or	Town, State
60%	Pages nent of nnt: tf ii		XX Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	i	lle Pres.	I I	-04 C	hurchyi 11	e, Maryland
770	permit. Pages Department of Important: If it ony injury or gance.		21. Signature of Funeral Service License	99		22. Name and Addre			LIGHT CHIVELLE	C. PALYACIA
7	20529		Marile U-En			1317 Cokes	sbury koa	d, Abingd	on, Maryl	and 21009
			23a. Part1. Enter the disease, or compare shock, or heart failure. List only of	e caused in at caused in	the death. Do not e.	enter the mode of dyir	ng, such as cardiad	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		HODKI	VS d'	YMPHO	MA		3 MONTHS
	Examiner				consequence of):	EPSIS				6 WEEKS
0		ner	Sequentially ils, conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):					
7.4	scuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	ACU		ENAL	FAILU	RE		3 MONTH
50	te be executed ysician and le burial-transit	cal Ex	resulting in death) Last	Due to (or as a	consequence of):					
30	ng physias the	dle		l						N
No.	The faw requires that the death certificate are has been signed by the attending phys page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of		- 7-			23d. Date of de	livery
-	that the death cer ed by the attendin detached for use	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown		3 □Ectopic pregnancy 5 □ Other <i>(specify)</i> _	<u> </u>		Month	Day Year
1 0	at the d by the	Phys	9 Unknown							
7 4	w requires that been signed t	by	Part II. Other significant conditions con	induting to death bu	t not resulting in the	underlying cause giv	ren in Part I.	23e. Did toba		the cause of death?
3 2	w requii	etec	HIDIZONINAL	ilanico	1	nocord	10			
NSKUP, Ronald	he fav e has ige 2	Completed	HEHUNG:	VANCOR	MYCIN	RESIST	LENT	24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
<u>a</u> <u>r</u>	ysician: The is certificate hadrector, page	Be Co	ENTERO COC 25. Was case referred to medical	eus			26 Place of Dea	1 ☐ Yes 2 ☐ th Check on one	No 1 □ Yes	2 2 No
\ \ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital:	nt 2 ER/Outpar	ient 3□ DOA Oth	00		ce 6 □Other (Spe	cify)
7	Attanding Physician: r death. sctor: Atter this certifica		27. Manner of □eath 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day		y Wor	y at k?	28d. Describe how		
Z is	l or Attandi after death. Director: A	cat	2 Accident investigation 3 Suicide 6 □ Could not be	28a Place of laive	a. Athoma farm		Yes 2 □ No	ORE Leasting (Core	at and Musican and D	
BISKU	for Attancation after deatl	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	street, factory, office		City or Town,	et and Number or Ri State)	urai Houte Number,
(0)	To the Hospital or Attanwihin 24 hours after death To the Funaral Director: completely filled in by the	alC	29a. Certifier 1 Certifying Phys	sician: To the best of	f my knowledge, de	eath occurred at the tin	ne, date and place	and due to the caus	se(s) and manner as	s stated.
#	he Ho in 24 I ha Fu pletely	Medical	(Check only 2 Medical Examination)	ner: On the basis of and manner stat	examination and/or	investigation, in my o	pinion, death occu	rred at the time, date	and place, and due	to the cause(s)
	To the within 2 To tha complet	Σ	29b. Signature and little of commier	0000	1	29c. Licens	e number		I. Date signed (Mont	
	141		N. Duro	TO DUCK	action of	DU	72630		14-03-	-20CH
	101		30. Name and address of person who co				BE.	-AIR M	D2101L	1_
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra		1	1		-71-	J
	Registi		APR 0 6 2004	palana ana	19 1	sports				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician March 31, 2004 12:22 Charles Burkhardt. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air Months Days Hours Min. Oct. 5, 1912 6. Sex 1 → M 2 □ F Birthplace (State or Foreign Country)
 Onlo 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 280-16-0999 91 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County of Health and Mental Hygiene.

Hem 27 Is marked other then "natural", or Hems 23a or 28a-f ahow other traumatic event, the Modical Exeminer must be notified at 1 Yes 2 No Director Harford Maryland Belcamp 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21017 USA 1400 Dalmation Place Apt T3 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1944–65 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12 Master Sergeant 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be be it William Burkhardt Elizabeth (mmn) Marling 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Georgette J. Burkhardt - Wife 1400 Dalmation Place, Apt T3, Belcamp, MD 21017 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If Ite
any injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 4/02/04
22. Name and Address of Facility McCon Towson, Maryland 21. Signal re of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, othern ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT **Physician** /Medical Due to (or as a consequence of): Examiner MYOCARDIALIWFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner NOT KNOWN sicien and burial-transit SEVERE ANEMIA Due to (or as a consequence of): use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 3 Probably 4 □Unknown 2 🗆 No 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 1 ☐ Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To 27. Manger of Death 1 Matural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D26344 of deat (Nem 23a) (Type, Print) UPPER CHESIA PEN KE MEDICAL CEATER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000

	•	For State Registrer 1. Desedent's Neme (First, Middle, Last)		Cer	tificate of D	eath		Reg. No.	3. Time of Death
Physici /Medic	cal	4e. Fecijity, Name (If not institution, give street and numi	OWN		4b_City, Town, or L	ocation of Death	Month		ear 440 pm
Examir Funeral Director	ier	VANTAGE HOUSE	Age (In yrs. last	birthday) Yrs.	COLUM If Under 1 Year Months Days	B/A If Under 24 Hrs. Hours Min.		HO	D. Birthplece (State or Foreign Country) Ohio
Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD Howard	10c. City, To	own or Loc					10d. Inside City Limits 1 ☐ Yes 2√ No
death with the Maryland ims 23a or 28a-f ehow	Funeral Director	10e. Sireet and Number 5400 Vantage Point Road			10f. Zip Code	.044	=	10g. Citizen of Wh	al Country?
irs after dea	by Funer	11. Marital Slatus 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deced Armed Force Armed Force (If Yes, Give Year or Date	⊠ No		Vas Decedent of His Yes, specify Cuban	panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		American Indian, While, etc. White
be filed within 72 hours after death with the Maryla ital Hygiene. Id other than "naturel", or items 23s or 28s-f ehovent. Its Medical Examerations to confine a	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary(Secondary (0-12) College (1-	10	(Give I life. E	lent's Usual Occupat kind of work done du DO NOT use retired)	iring most of wor	rking	16b. Kind of Busi	
	Be	17. Father's Name (First, Middle, Last) Robert Watson	1	re	search an	18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
s 1 and 2 should be f Health and Menta Item 27 le marked other traumatic ev	To	19a. Informant's Name/Relationship (Type, Print) Vantage House		540	g Address <i>(Street ar</i> O Vantage	nd Number or Ru	ral Route Number	er, City or Town, Stumbia, Mi	21044
9° = 5		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from S 4 Donation 5 Other (Specify)	come	e of Dispos etery, crem	sition (Name of natory or other place,)	Date	20c. Location - Ci	ty or Town, Slate
permit. Par Departmen Important: any injury once.		21a, Pert 1, Inter the disease, or complications that ca	rector	St La Do not enle	Name and Address TE Anato Itimore, or the mode of dying,	my Board MD 2120 such as cardiad	655 W		Approximate
Physician /Medical		Immediete Cause (Final disease or condition resulting in death)	r as a consequent	er	t De	eme	tig		Interval Between Onset and Death
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events	r as a consequence	So v	1'S D	siseo	ise		-
ificate be executed g physicien and as the burial-transit	edicai Exa	resulting in death) Last Due to (o	ras a consequence	ce of):	se sec	ndan	to De	crese	
death certif e attending od for use as	Physician/Me	in the past 12 months?	ome of pregnancy th 2 Fetal dea nt at time of death	ath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month	•
	ρ	Part II. Other significant conditions contributing to dea	th but not resultin	g in the ur	nderlying cause giver	n in Part I.		obacco use contrib /es 2 \(\subseteq \text{No} \(3 \)	ute to the cause of death?
The law ate has b	Completed	Decondition Anemia	ui -	5			24a. Was autor perfo 1 🗆 Yes	prior prior	ore autopsy findings available or to completion of cause of ath? Yes 22 No
ding Physiclan: Th h. After this certificate funeral director, pag	n: To Be	27. Manper of Death 28a. Date of		Outpatient b. Time of Injury	Other	4 Nursing H		one) dence 6 □Other now injury occurred	
or Attending Physician: after death. Director: After this certification by the funeral director.	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of	of Injury - At home g, etc. (Specify)		M 1 🗆 Y	es 2 □ No	28f. Location (3 City or Tov		or Rural Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tr	edical C	29a. Certifier 1 Certifying Physician: To the band one) 2 Medical Examiner: On the band one)	sis of examination	dge, death and/or inv	occurred at the time vestigation, in my opi	a, date and place nion, death occu	e, and due to the irred at the time,	cause(s) end mann date and place, and	ner as stated. d due to the cause(s)
To t Withi To t	M	29b. Signature and title of certifier	27, w		29c. License	number 425		29d. Date signed (Month, Day, Year)
St	ate		of death (Item 23	50	rint)	wealt	e AV		

			1 _ State	State of Mary		artment of H			ene g. No. 2004	10270
	A. A	k.	Registrar 1. Decedent's Name (First, Middle, Last)			Timoato or t	Dou	2. Date of Death	1	3. Time of Death
W.	Physicia	-	Judy Kay Bittner					APRIL.	Day Year	3:10 P.M.
	/Medic Examin		4a. Fecility Name (If not institution, give st	reet and number)		4b. City, Town, or	r Location of Death		4c. County of Deat	
	LAUTINI		SAINT AGNES	HEALTHCA	PRE	BALT	MORE		N/A	
18	Funeral	- Y==	Social Security Number 6. Sex	7. Age (In	yrs. last birthday 52 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign
· 基	Director		212-58-4745	M Zalf	OZ Yrs.				10 - 1	ryland
	and		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	Mary f sho	jo	Maryland Baltimor	е :	Baltimor	e Highlan	ds			1 ☐ Yes 2 📉 No
	r 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	
	death with the Maryland ms 23a or 28a-f show mast be notified at	a D	2804 Oak Grove Ave	•		21227			U. S. A.	
	dea	Funeral	11. Marital Status	Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
ë	filed within 72 hours after Hygiene. other than "naturel", or Ite ent, I're Medical Exercities		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a Dece	edent's Usual Occup	nation	1	6b. Kind of Business/	
<u>ς</u>	in 72	Completed	(Specify only highest grade	completed)	(Give	b kind of work done of DO NOT use retired	during most of world)	king		,
212	i with	шо	Elementary/Secpretary (0-12)	College (1-4or 5+)	Home	maker			Own Home	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Menth Hygiene. Is marked other than "naturel", or items 23a or 28a-1 show armatic event, Ira Medical Estarch at mastic event, Ira Medical Estarch at mastic event.	BeC	17. Father's Name (First, Middle, Last) William C. Tawes					ne <i>(First, Middle, M</i> eth I. Be		
<u>a</u>	should b and Menti marked	_O	WIIIIam O. Iawes							
a			19a. Informant's Name/Relationship (Type James W. Bittner	oe, Print)		ing Address (Street 4 Oak Gro			City or Town, State, 2	
	1 and Health em 27 ther to		20a. Method of Disposition	2	Ob. Place of Disp		ve Ave.		20c. Location - City or	Is, MD. 21227
Baltimore,	Pages nent of H int: If ite ury or of		1 X Burial 2 ☐ Cremation 3 ☐ Re	amoval from State	cemetery, cre	en Memori			79	
	rtmer rtant njury		*4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service License						Glen Burn	.re, m
Ba	permit. Departr Importa		John a	24		Ambrose F 2719 Hamm	uneral Ho onds Feri	ome of La rv Rd. La	nsdowne nsdowne, M	D. 21227
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the						Approximate Interval Between
	Physician		tmmediate Cause (Final	Acute Contract into	Munca	RDIAL 1	NEARC	tion		Colic Cavs
	/Medical		disease or condition resulting in death)	Due to (or as a co		NOTE -	INTINO	11014		TOM CIAUS
	Examiner		Sequentially list conditions.	HYPERI	mount	16				tuerly years
	D #	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	ensequence of):					. 1 (
	and and trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a co	Sequence of:	LITUS				Twenty-twe years
8760,	ate be executed hysician and the burial-transit	aiE		CORONA	. ^	TERY DI	SEASE			ton vones
687	eath certificate be executed attending physician and for use as the burial-transit	edicai	0	COROTT	1 1/2					11.14
Box (death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p		Os			23d. Date of del	ivery
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 Mo	1 Live birth 2 4 Pregnant at time		□Ectopic pregnancy □ Other (specify) _	у		Month	Day Year
P.0.		hys	9 Unknown	9□ Unknown						
Ś	res tha igned be del	þ	Part II. Other significant conditions con	tributing to death but no	ot resulting in the	underlying cause giv	en in Part I.		acco use contribute to	o the cause of death?
ord	w requir been si should	ted	CHRONIC KEN	HT INDA	TICIFI	VCY		1 1 10		
Vital Record	8 S C	Completed						24a. Was ar autopsy perform	v prior to	utopsy findings available completion of cause of
E F								1 ☐ Yes 2	IZNo 1 □ Yes	2 □ No
Z.		Be	25. Was case referred to medical examiner?	ospital:	2[] ED/0-11	ent 3 DOA Oth	ner	ath (Check only one		a:F-1
of	Phys rr this aral dii	. To	1 Yes 2 No	28a. Date of tnjury	2 ER/Outpation	of 28c. Injur	ry at	28d. Describe ho	nce 6 Other (Spe w injury occurred	sny)
on	nding th: : Afte	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Intury	M 1 🗆	rk? Yes 2 🗌 No			
Division	Atter ector by th	iffice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (5	At home, farm, s	treet, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ural Route Number,
	rs afte at Dir ed in	Certification:		, , , , ,						h
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical		sician: To the best of m ner: On the basis of exa and manner stated	amination and/or					
	othe	Mec	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Mont	h, Day, Year)
	+ > + 0		gonathan Sopren m	o Attenomic	s CAKUTON	MARYLA MARYLA	NO B OW	11111 0	Logn I.	2004
	10		30. Name and address of person who co	mpleted cause of death	n (Item 23a) (Type	, Print)		- · · · · · F	11.17	
	,		JONATHAN SAFREN	1 M.O. 344	9 WILKE	NS AVENUE	- SUITE 3	00 BALTIN	DRE, MARY	AND 21042
	Sta		31. Date filed (Marth Pay (Year) 200	32. Régistrar's	Signature A	Soore				
	Regist	al	100	17		piporest.				

JUDY KAY BITTHER

		1	For State Registrar	State of I	Maryland .				ealth a D <i>eath</i>	nd Me	ental Hy	giene Reg. No.	2004	10	280
		1	1. Decedent's Name (First, Middle,	Last)	-					- 1	2. Date of De Month	Dav	Year	3. Time o	
	Physicia /Medic		Claravada Brigh	nt							April			1:2	PM
	Examin		4a. Facility Name (If not institution,	give street and numb	er)		4b. City,		Location of				County of Death		
			BON JEU OUV	Hospe ful			150		more			N/2		1. (01-1-	
	Funeral			5. Sex 7. 1 ☐ M 2 🔀 F	Age (In yrs. last	t birthday) O Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	th ly, Year)	Cot	plece (State intry)	or Foreign
	Director		410-68-9431		- 0	0 113.					Jun 29	, 19	43 KY		
	and **	-	Usual Residence of Decedent 10a, State 10b, County		10c. City, T	Town or Lo	cation							10d. Inside (City Limits
	fanyl faho	5	MD N/A		Balti	more								⊅€]Ye	s 2 No
	the 1	rect	10e, Street and Number				10f. Zig	Code				10g. Citiz	zen of What Co	intry?	
	With With	ā	1713 Cole Street	<u>.</u>			212	23				Unit	ed Stat	es	
	death with the Maryland ms 23a or 28a-f ahow f must be notified at	Funeral Director	11. Marital Status	12. Was Decede		13.	Was Dece	dent of H	ispanic Orig	gin? (Spe	cify Yes or No)- 1	14. Race - Amer Black, White		
0	or ite		1 Never Married 2 Marrie	d 1 Yes 2			1 Tes, spe 1 ☐ Yes	-00	Specify:	, Fuerto i	iloan, ott.)		Specify:	, 610.	
<u></u>	rai', c	þ	3 ☐ Widowed 4 ♣ Divorced	Year or Date	es:		1 . 63	245 140	Openy.			E	Black		
2	72 hc natu	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced (Give	kind of wo	rk done	during most	of working	ng		nd of Business/I		
2	ithin	du	Elementary/Secondary (0-12)	College (1-4			DO NOT L	se retired	<i>1)</i>			Hous	sekeepir	ıg	
Maryland 21215-0036	filed within 72 hours after Hygiene. Sther than "natural", or ite ent, the Medical Examire		9 17. Father's Name (First, Middle, L.	acti	L	Oomes	tic		18 Mothe	r's Name	(First, Middle	Maiden	Sumame)		
<u>n</u>	be fill	Be									nie Br		, , , , , , , , , , , , , , , , , , ,		
3	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If I feath and Mental Hygiene. If I feath 27 is marked other than "natural", or items 23a or 28a-f ahow or other fraumatic avent, the Medical Examiner must be notified at	2	William Bryant 1 19a. Informant's Name/Relationshi			10h Mailir	an Addres	Street					Town, State, Z	ip Code)	
<u>a</u>	12 st h and 7 ia n fraun										imore,			,,,,	
e)	1 and 2 Health tem 27		Ms. Tawanada Mur 20a. Method of Disposition	.pny -baug	20b. Plac	e of Dispo	sition (Na	me of			ate		cation - City or	Town, State	
وّ	Pages nent of I ant: If its ary or o		1 Burial 2 Cremation		ate	netery, crer			_		ar 9	Dol+	imore,	MD	
Baltimore,	그 문 뿐 중		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L	-	Mou	nt Zi			ery ss of Facilit		004	Ват	rmore,	MU	
Ba	Deparement Deparement		21. Signature of Pulleral Service L	0011300		С	alvi	L.	Willi	ams	Funera	1 Hor	ne, P.A.		
			23a. Part1. Enter the disease, or o	complications that cau	used the death.	Do not ent	818 I	ast de ol dyin	Balta	cardiac o	Stree r respiratory a	t Ba	altimore	Approxim Interval B	ate
8760,	cate be executed by yestelan and by yestelan and burial-transit bu	dical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Phos Due to (or b. Due to (or	as a consequent	nce ol):	raliz Irri valu	out est	h Ta	ad wer	100	ævín.	Dar	nset and	Thrs Thrs
.O. Box 6	death certifi e attending od for use as	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months2 1 ☐ Yes 2 ☐ Hot 9 ☐ Unknown		th 2 Fetal dent at time of dea	eath 3[⊒Ectopic p □ Other (s		,			2	23d. Date of deli Month	very Day	Year
ds, P	w requires that the been signed by the should be detache		Part II. Other significant condition	ns contributing to dea	ith but not result	erds	inderlying	cause giv	en in Part I				ise contribute to		
Secor	has pe 2	Completed									24a. Wa: auto perf	psy omed?	death?	ompletion of	s available cause ol
a	ician: Th certificate rector, pag								OC Place	- f D sh	1 Yes	2 2 100	1 L Yes	2 No	
Ζ	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	patient 2□El	R/Outpatie	nt 3 🗆 D	OA Ott	100		(Check only		6 □Other (Spe	nifiz)	
of	S 5	10	1 Yes 2 ANO	28a. Date of		8b. Time o		28c. Injur	ry at		28d. Describe			шу)	
uo	ding Ph h. After th funeral	tol	1 ☑ Natural 5 ☐ Pending	,	, Day Year)	Injury	м	Woi 1 □	rk? ∣Yes 2 🗀	No					
Division of Vital Record	I or Attanding after death. Director: After	ertification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determine	ot be 28e. Place of	of Injury - At hom g, etc. (Specify)	ie, larm, st	reet, lacto	ry, office	1,517	ur.	28f. Location City or To	(Street an own, State	d Number or Ru	ıral Route Ni	umber,
_	Hospita 4 hours Funeral ely filled	edical Co	29a. Certifier 1 Certifyin (Check only one) 1 Medical 6	g Physician: To the texaminer: On the base	sis of examination	ledge, deat on and/or in	th occurrenvestigation	d at the ti	me, date ar opinion, dea	nd place, a	and due to the	cause(s) , date and	and manner as i place, and due	stated. to the cause	9(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	101	1		25	c. Licens	se number	-		29d. Dat	te signed (Mont		
	- s - ō		LaMus	+ (Alas	A WI)		000	152.	591	7	An	16.0	100	
	n		30. Name and address of person	who completed cause	of death (Item 3	23a) (Tvna	Print) 2	,		0		1		7009 211	
	9		la Hout - Sins	th 21	200 11	1. 1	all	MO re	- 57	_	Will	mer	MD	211	23
ō	St	ate	31. Date filed (Month, Day, Year)	2 €. Re	gistrar's Signatu	ire	-A.					1	/		
	Regist	rar	ADD O 6 2	nn/ 1882	17 1 Dr	1									

	1 - State Registrar		tificate of D			. No. 200	
Physician	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	
/Medical	Elizabeth G. Bossler		4b. City, Town, or L	acation of Donth	APRIL	4c. County of De	
Examiner	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Co	enter	4b. City, Town, or L	Towso	n		timore
Funeral	4DM offe	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	'ear) 9. B	irthplace (State or Foreign Country)
Director	194-28-7464 ^{1□M 2} ₹ 88	Yrs.			11/16/19	15 Pe	nnsylvania
D M	Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or Lo	cation				10d. Inside City Limits
a-f sh illed	MD Washington	Hagerst	own				1 ☐ Yes 2 ☐ No X
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time X7 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What	Country?
s 23a	10817 Roessner Avenue	- II - 123	21740	nania Origina (Spo	noity Van ar Na	U.S.A.	nerican Indian,
it, or itams 23s xaminer met.	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	In U.S. 13. 1	Was Decedent of His f Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)	Black, Wh	
by by	3 ₩idowed 4 Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐xtNo	Specify:		Specify: W.	hite
ygiene. terthan "naturi t, the Mucral I	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupat kind of work done du	ion iring most of worki	ng 16	b. Kind of Busines	s/Industry
than the month	Elementary/Secondary (0-12) College (1-4or 5+) 12TH		00 NOT use retired) emaker			Own Ho	me.
e Cc	17. Father's Name (First, Middle, Last)	110111		18. Mother's Name	(First, Middle, Ma		iie .
Mental Mental arked of the Mental To B	Charles Sholtz			Sophia	Godve	lis	<u> </u>
is me	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street an			•	
m 27 m 27 her tr	Barbara Powell / Daughter	10813 0b. Place of Dispo	Roessner		~	MD 217	
or of	Burial 2 Cremation 3 Removal from State	cemetery, crer	natory or other place,)			
injury	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		Memorial E Name and Address				Township, PA
any ir	12/		8521 Lock	1110			Home, P.A.
	232 Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent					Approximate Interval Between
sician	Immediate Cause (Final disease or condition CARD IOGE	ENIC SHO	DCK				Onset and Death
edical miner	resulting in death) Due to (or as a co		~ F>/~~~ ~ /~ k i				
	Sequentially list conditions, if any, leading to immediate b. MYDCARD I						
rial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events c		Y DISEAS	osoba piko			
rial-tra	resulting in death) Last Due to (or as a co						
physician and the burial-transit the burial-transit dical Examir	d						
~ # I O	IF FEMALE: 23c. If yes, outcome of pr	regnancy			-	23d. Date of o	elivery
d by the attending letached for use a Physician/M	in the past 12 months? 1 Voe 1 Voe 2 No.	Fetal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
detached f	9 ☐ Unknown						
go e d	Part II. Other significant conditions contributing to death but no RENAL FAILURE	t resulting in the u	nderlying cause giver	n in Part I.			to the cause of death? Probably 4 Munknown
should I	KENAL PATEORE					2 No 3	
S C D					24a. Was an autopsy	prior to	autopsy findings available completion of cause of
	OF Was seen referred to medical			00 Plans of Parath	performe	No 1□Yı	as 2□No
	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{N} \) No Hospital: 1 \(\subseteq \text{Inpatient} \)	2 □ ER/Outpatier		100	n (Check only one) me 5 ☐ Residenc		necify)
# S	27. Manner of Death 28a. Date of Injury	28b. Time o		A STATE OF THE PARTY OF THE PAR	28d. Describe how		
ctor: Aft y the fur ficatio	2 Accident investigation	,,-,		es 2 □No			
0 0	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	reet, factory, office	1	28f. Location (Stre City or Town,		Rural Route Number,
	29a. Certifier 1X Certifying Physician: To the best of m	v knowledge deat	h occurred at the time	date and place	and due to the cau	se(s) and manner	as stated
F. P. S.	(Check only one) 2 Medical Examiner: On the basis of examiner on the basis of examiner on the basis of examiner on the basis of examiner on the basis of examiner.						
within 24 hay To the Function of the formal completely Medical	29b. Signature and title of certifier) W	29c. License	number	290	d. Date signed (Mo	nth, Day, Year)
1	> Kchad L. Linth	cum	D318	26	.4	-4-0	4
V	30. Name and address of person who completed cause of death	(Item 23a) (Type,					
	RICHARD L. LINTHICUM, M. II 31. Date filed (Month, Day, Year) 32. Registrar's		OSLER I	DRIVE.	TOWSON,	MARYLA	ND 21204
State	APP 0 6 2001		Loans	5 ,			

MAN

AUBREY BEVERLY UNK 04-103

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death

Physician
/Medical
Examiner

For State Registrar Decedent's Name (First, Middle, Last)
 Aubrey Dillard Beverly

2. Date of Death Day 2004 Month March 29,

2330 P M

Funeral

Director

Completed by Funeral

Be

2

Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

Director f Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28a-f show other traumatic event, the Modical Exambles man be notified at Pages 1 and 2 should be filed permit. Pages 1 Department of H Important: If ite eny injury or ot once:

Physician /Medical

Examiner

attending physicien and for use as the burial-transit

ed by the a

certificate has irector, page 2 s

funeral director,

within 24 hours after death To the Funerel Director:, completely filled in by the t

Hospital

The law requires that the death certificate be executed

P.O. Box 68760,

of Vital Records,

Division

Baltimore, Maryland 21215-0036

4a. Fecility Name (If not institution, give street and number) 1918 W. Pratt Street 5. Social Security Number 7. Age (In yrs. last birthday) 214-44-0353 12 M 2 T F

4b. City, Town, or Location of Death Baltimore

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 29, 1946 Birthplace (State or Foreign Country) **Virginia**

Baltimore City

Usual Residence of Decedent 10b. County 10a. State

Baltimore City

10c. City, Town or Location

10f. Zip Code

Months

Baltimore City

21230

10d. Inside City Limits 1 Yes 2 No

1243 Carroll Street

10e. Street and Number

MD

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Curan, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No

14. Race - American Indian. White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

Sister

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) did not work

16b. Kind of Business/Industry did not work

4c. County of Death

10g. Citizen of What Country? U.S.A.

17. Father's Name (First, Middle, Last)

Never Married 2☐ Married

3 ☐ Widowed 4 ☐ Divorced

Glen Beverly

18. Mother's Name (First, Middle, Maiden Sumame)

Lothia Lee Johns

19a. Informant's Name/Relationship (Type, Print)

Ms. Catherine Keaton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5481 Levering Ave Elkridge, Maryland 21075

20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation Services, Inc. 04/02/2004

Date

20c. Location - City or Town, State Sykesville, Maryland

21. Signature of Funeral Serv

22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or flear failure. Vist only one cause on each line.

Onset and Death

Year

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

Smoke and soot inhalation and thermal injuries Due to (or as a consequence of): Due to (or as a consequence of)

Due to (or as a consequence of):

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy 2 Fetal death

3 ☐Ectopic pregnancy 4☐ Pregnant at time of death 5 Other (specify)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

no use

23d. Date of delivery Day Month

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 No

23e. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one)

111 Penn Street, Baltimore, Maryland 21201

24b. Were autopsy findings available prior to completion of cause of death?

1 № Yes 2 □ No

25. Was case referred to medical 1 X yes 2 □ No

3 Suicide

asha

4 Homicide

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

March 29 2004 6 ☐ Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA PM 10:30

28c. Injury at Work? 1 ☐ Yes 2 🗷 No

Other: 4 \square Nursing Home 5 \square Residence SYDTher (Specify) At SCENE 28d. Describe how injury occurred corelen use of condlex per arson report

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1918 W Fratt, Buthwee, MD

(Check only 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

lsen MI) 30. Name and address of pers who completed cause of eath (Item 23a) (Type, Print)

Laveenberg

O.C.M.E.

March 30, 2004

Registrar

31. Date filed (Month, Day, Year) APR 0 6 2004

M.D. 22. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 000Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month **Physician** 7:15p /Medical 4b. City. Town, or Locetion of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE N/A ROCKGLENN NURSING CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 12-7-1910 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 DM 2□ F NORTH CAROLINA Yrs 93 Director 217-07-1904 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r then "neturel", or items 23e or 28e-f show the Modical Exerciper nast be notified at 1 No Yes 2 No Director BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA Funeral 501 DOLPHIN ST APT 916 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -0-LABORER CONSTRUCTION -6-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SARAH BLUE HERBERT D. BLUE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 921 WILDWOOD PKWY, BALTIMORE, MARYLAND 21229 AUDREY CARTER (DAUGHTER) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) ARBUTUS MEMORIAL PARK 4-6-2004 BALTIMORE, MARYLAND 21. Signatur y of Funeral Service Licens GUINZVERE, REDD 22. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner attending physician and for use es the burial-trensit or Attending Physicien: The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): resulting in death) Lest Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed by ACCIDENT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? has 1 Yes 2/ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes this 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No efter death. 2 Accident within 24 hours efter death

To the Funerel Director: /
completely filled in by the f 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitai 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JI MORE 2120 15/11 31. Date filed (Month, Day, Year) 32. Registrar's Signature State outh 2-0341 APR 0 6 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2001 10284 1 - For Stata Registrar Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** RICHARD 7:30 AM 3004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE BALTIMORE ANET 60006 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F Vrs JAN, 21, 1933 MARY 220-30-2190 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show 7 is marked other than "naturel", or items 23s or 28e-f shor treumstic event, the Medical Examiner r-ust by mutified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? INITED (4000 12. Was Decedent Ever in U.S. Amed Forces? 1 XYes 2 □ No IYYes, Give Year or Dates: 1 205 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: BLACK \$ permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", a any joilury or other treumatic event, the Medical Exemples. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4BORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEGGY JE LOCOLO LANETTE RD, BALTIMORE MD 212-CO.

Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ANIATOMY GIFTS REG 4/4/04 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LUNG CANCER 6 montas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying trues [Diseases of Jun] Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 1∐ Yes 2∫2 No the Hospitel or Attending Physicien: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04 D GO SS 034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEVENE HUSPITAL CENTER DAIRLES R CONKURY FRANKLIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 6 2004 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

APR 0 6 2004

MICHEL KAFROUNI

M. Kaftouni, MI

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COODSAHARITAN HOCPITAL

5601 LOCHRAVEN BIVD BALTIMORE MD 21239

RESOUD

29d. Date signed (Month, Day, Year)

04, 2004

		•	For State Registrar		State of		nd / Depa		t of H	lealth a	and M	lental Hy		200	4 10286	
			1. Decedent's Name (First, M	iddle, Las	st)							2. Date of De Month	ath Day	Year	3. Time of Death	
	Physici /Medic	_	ALICE	G		CORE	Y					MARCH	29	2004		
7	Examin		4a. Fecility Name (If not institu	ition, give	e street and num	ber)	_	4b. City,	Town, or	Location of	of Death		4c.	County of Dea	ath	
			LEONARDTOWN H	SP1T/	AL			L u	EONAR	DTOWN			S	T. MARY	S	
	Funeral		5. Social Security Number	6. S		7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Di	th ay, Year)	9. Bi	rthplace (State or Foreign country)	
	Director		112-14-7681	1	□ M 2)() (F	93	Yrs.	Morale	50,0			11/30/1			TT, NY	
	p ,	}	Usual Residence of Deceden 10a. State 10b. Cou			10c Ci	ty, Town or Lo	neation							10d. Inside City Limits	
	the Marylar 28a-f ahow notified at	2	MARYLAND		MARYS	100. 01	Leonard								1 ☐ Yes 2 XX No	
	8a-1	ctc	111000000000000000000000000000000000000	JI. 1	-MICLO		Leonaru					1	10 00			
	ith it	Funeral Director	10e. Street and Number		COLIDT	DT 4405		10f. Zip	Code					zen of What C	ountry?	
	lterna 23a	ra .		LANE		PT 1126	10				-:-0 (0			USA 14. Race - Am	adaa ladaa	
	er de	nue	11. Marital Status		12. Was Dece Armed For 1 Tyes	ces?	J.S. 13.	If Yes, spec	offy Cuba	in, Mexicar	n, Puerto	ecity Yes or No Rican, etc.))-	Bleck, Whi		
36	rs aft	by F	1 Never Married 2 1 XX Widowed 4 Divor		If Yes, Give	9		1 🗆 Yes	XX No	Specify:				Specify:	HITE	
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or liema 23a or 28a-f ahow ta Medigal Examana must be notifiad at	ed t	15. Dece				16a, Dece	dent's Usua	al Occupi	ation			16b. Kir	nd of Business	s/Industry	
5	n 72	slet	(Specify only hi	ghest gra	ide completed)		(Give	kind of wo	rk done d se retired	during mos	t of worki	ng		LAND COL		
12	the the	Completed	Elementary/Secondary (0-1	2)	College (1-	4or 5+)		WORKE							CIAL SERVICES	
	filed with Hygiene. other than		17. Father's Name (First, Mid	die, Last))					18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)		
an	should be filed withir and Mental Hygiene. marked other than matic avent, I.e.M.	To Be	SCOTT GILLETT								ALE	NE VER	NON			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene Item 27 Is marked other than "natural", or Itema 23a or 28a-1 ahov Item 27 Is marked other than "natural", or Itema 23a or 28a-1 ahov other traumatic avent, Ira Medical Examana must be notified as	-	19a. Informant's Name/Relat	onship (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	I Route Numb	er, City or	Town, State,	Zip Code)	
S	and 2 sealth and 2 sealth and 27 is		JOAN COREY				17841	RIVER	SHOR	E DRIV	E, TA	LL TIMBE	RS. MA	RYLAND 2	20690	
ē,	Heart Heart term		20a. Method of Disposition			20b. I	Place of Dispo	sition (Nar	ne of			Date		cation - City or		
2	ages ant of t: If if		1XXBurial 2 ☐ Cremati 4 ☐ Donetion 5 ☐ Othe			State	GLENWOO			(8)	4/2/	2004	HOME	R NEW YO	JDK	
Baltimore,	nit. Pa partmen ortant: injury		21. Signature of Funeral Sen					2. Name an		ss of Facilit		MARYLAND				
Ba	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr once.		NA CORDA	W 1.	RY FINK	#M01148						LEN BURN				
			23a. Part . Enter the disease shock or heart failure.											KILAND Z	Approximate	
	Physician /Medical Examiner		shock or heart failure. Immediate Cause (Final disease or condition resulting in death)	bist only	a. Go	or as a consec	Mybian	dial	In	farc	10				Interval Between Onset and Death	
	i i	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Į	b. Due to (c	or as a consec	quence of):		KHE	N	100	Jea Sa				
,092	be executed ician and burial-transit	cai Examiner	that initiated events resulting in death) Last	l	c. Due to (or as a consec	quence of):									
687	phys phys the				d											
.O. Box (The law requires that the death centificate be executed ate bas been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown			rth 2 ☐ Fete ant at time of c	el death 3[∃Ectopic pr ∃ Other (sp					2	3d. Date of de Month	elivery Day Year	
Records, P.	ires that signed by d be deta	þ	Part II. Other significant con	ditions o	contributing to de	ath but not re	sulting in the u	inderlying c	ause give	en in Part I			obacco us		to the cause of death?	
Ö	w requir been si should	ete										04- 146		04h W	V	
3ec	e law has ja 2 s	Completed									_	24a. Was auto		prior to death?	utopsy findings available completion of cause of	
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ō	iling Physicien: The lav n. After this certificate has funeral director, page 2		1 Yes 2 No 27. Manner of Death 1 Natural 5 Pe	nding estigation	g (Month, Day Year) Injury Work?								asidence 6 Other (Specify) se how injury occurred			
Division	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be termined	e 28e. Place	of Injury - At h	nome, farm, sti fy)					28f. Location (City or To			Rural Route Number,	
	s Hospite 24 hours e Funerel etely filled	Medical C	29a. Certifier 1 Cert (Check only one) 2 Med	fying Ph	nysician: To the miner: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of ce	tifier	2111	10		290	. License	e number			29d. Date	signed (Mon	th, Day, Year)	
	->-0		Mo	wi	ZKKN	MM	name of the same o	2	50	368	120	y	02	301	74	
			30. Name and address of per	son who	completed caus	a of death (Ito	m 23a) (Type		U U	200)	- 0	1-		
	10								1037.	D.M.C.	7	006==		·		
	Sta	ite	DR. MARC F 31. Date filed (Month, Day, Y			SMH P(egistrar's Sign		-		RDTOW	N MD	20650				
	Regist		NDD 0 6 200	Α	Senent	کر سا		astr	1							

04-02285 Linda Harvey RJD

A			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death										1 -4	10287		
			Decedent's Name (First, Middle, Last) 2. Date of Death											ear	3. Time of Death	
A.	Physici /Medio		LINDA COOK CLAR		April					1705P. M						
	Examir											40	4c. County of Death			
			North Arundel H				ırnie		Anne A							
ľ	Funeral Director	To Be Completed by Funeral Director	223-13-3345	3. Sex 1 ☐ M 2 X F 7	Age (In yrs. 42	Months	Days Hours Min. 8. Date of (Month)			8. Date of Bir (Month, Da 2-10-	(Birth 9. B (Day, Year) VI			lece (State or Foreign (N) INIA		
	and *		Usuel Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits			
	Aaryla f • ho		MD ANNE A	RUNDEL		N BURN									1 Yes 2 No	
	28a-		10e. Street and Number 10f. Zip Code 10g. Citizen of What C										at Coun	try?		
	3 with															
92	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23s or 28s-f show any injury or other traumatic event, it a Medical Examinar must be notified at once.		11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	ent Ever in U. es? • No		Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e					tc.) Black, W			American Indian, Vhite, etc. WHITE		
21215-0036	tural		15. Decedent's	Year or Date	95.	16a Dece	dent's Usua	d Occupa	ntion			16b K	(ind of Busin	ness/Inc	lusto/	
5	in 72 n "na		(Specify only highest	grade completed)		(Give	kind of wor DO NDT us	k done a	lurina mos	t of worki	ing	100. 1	and or bush	1622/1110	lustry	
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ַק	e filec othe ont,		17. Father's Name (First, Middle, L.	ast)		1			18. Mothe	r's Name	(First, Middle,	Maider	Sumame)			
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Maryland	2 sho and ? is ma		19a. Informant's Name/Relationshi	p (Type, Print)			-				l Route Numbe			ate, Zip	Code)	
	and and and and and and and and and and		MR. MICHAEL HARV	YEY/ HUSBA	ND	721 D	ELMAR	AVE	. GLE	EN BU	JRNIE, 1	4D 2	1061			
ore	of H of H if ite		20a. Method of Disposition 12 Burial 2 Cremation 3	I ∏Removal from St.		Place of Dispo semetery, crer	sition (Nam natory or ot	ne of ther place	9)		Date	20c. L	ocation - Cit	y or To	wn, Stete	
E	ment ment tant: jury		*4 □Donation 5 □ Other (Spe	ocify)		T HAMP	TON M	EMOR	IAL	4-7-	-2004	RIC	HMOND	٦ ,	7A	
Baltimore,	Depar Depar Impor any in	L.U	21. Signature of man Service Li		1120		SECO:			, 91	NGLETOI GLEN BI					
10	Physician /Medical		21a. Part1. Enter the disease, or c shock, or heart failure. List of inmediate Cause (Final disease or condition resulting in death)	a. PULM	on line.	1 TH	er the mode					rest,			Approximate Interval Between Onset and Death	
,8760,	ficate be executed physician and sthe burial-transit	Physician/Medical Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):													
P.O. Box 6 hat the death certifi	ires that the death certifica signed by the attending pt d be detached for use as t											23d. Date o Month	*			
	uires that n signed b id be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the underlying cause given in Part I.										a cause of death?			
I Kecords,	The law requir ate has been si page 2 should	Be Completed											prio	r to coπ th2	sy findings available apletion of cause of	
/IIa	ician: Th certificate rector, pag		25. Was case referred to medical examiner?	Also to t		11.7.7		- 1		of Death	Check only o					
	Physic this c	2	1 → Yes 2 □ No)			
Ē	ding P. h. After I		27. Manner of Death 1 → Natural 5 → Pending 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Injury 48b. Time of 28c. Injury at 28d. Describe how injury occurred Injury 48b. Time of 18c. Injury at 28d. Describe how injury occurred													
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	To the Hospital or Attanding Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner shield.												ited. the cause(s)	
	To the within To the Comple	Me	29b. Signature and title of certifier O.C.M.E. 29c. License number O.C.M.E. 29d. Date signed (Mont													
	Sta	•	30. Name and address of person with the state	A. Kore	of death (Item	6	Spars		enn St	treet	t, Balt	imor	e, Ma	ryl	and 21201	

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 4, Day 2004 Year **Physician** 7:45 p M Estella Catherine Cress /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Owings Mills 154 S. Ritters Lane 7. Age (In yrs. last birthday) 64 Yrs. Months Days Hours Min. May 103, 1939 5. Social Security Number 9. Birthplece (State or Foreign **Funeral** 1 ☐ M 2 💢 F Maryland 214-38-9616 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits nd other than "natural", or Itams 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Baltimore Owings Mills Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 154 S. Ritters Lane 21117 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ (No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper Machine Shop Pages 1 and 2 should be filed in nent of Health and Mental Hygis ant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mae Poole Walter Arbogast 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 154 S. Ritters Lane, Owings Mills, Md. 21117 Leon V. Cress - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State Lake View Mem. Park April 7, 2004 Sykesville, Md. *4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Service Licenses 22. Name and Address of Facility Echardt Funeral Chavel, P.A.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

| Description of the content 21117 Ma. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 1ALIGNAN **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗖 No 9 Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ▼No 2 this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Director: After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospitel within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D32012 11722 REISTERSTOWN. RD. 30. Name and address of person who comple ed cause of death (Item 23a) (Type, Print) FPHRAIM DAGADU, nu 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 APR 6 Registrar

Joseph Franci 04-02256		se Type or Print	in Black I	ndelible Ink. E	Ensure All C	opies Aı	re Legible.	
crn	1 - For State Registrar	State of Mary		partment of Hea ertificate of De			ne No.2004	10289
Physician	1. Decedent's Name (First, Middle	-ONANCIS	Corso		2, 1	Date of Death	Day Year 01 2004	3. Time of Death
/Medical Examiner	A . C WA Bloom a life was boards of a	-		4b. City, Town, or Loc Annapo			4c. County of Death	h
Funeral Director	5. Social Security Number 214-46-86-16		n yrs. last birthda	y) If Under 1 Year If	Under 24 Hrs. 8, [Date of Birth Month, Day, Ye	9. Birti	hplace (State or Foreign unitry)
D	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or		_			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
6 after death with the Ma or tems 23s or 28s-fai cher must be routified Funerral Director	10e. Street and Number	mack C:		10f. Zip Code	2 2 3	10g.	. Citizen of What Co	
	11. Marital Status 1 Never Married 2 Mari	If Yes, Give	er in U.S. 13	Was Decedent of Hispa If Yes, specify Cuban, N 1 ☐ Yes 2 1 No S	anic Origin? (Specify Mexican, Puerto Rica Specify:	Yes or No- n, etc.)	14. Race - Ame Black, White	
e, Maryland 21215-0036 1 and 2 should be filed within 72 hours alt Health and Mental Hygiene. The marked other than "natural", or wher traumatic event, the Medical Erant To Be Completed by F	3	Year or Dates: 's Education st grade completed)	(Giv	redent's Usual Occupation re kind of work done during DO NOT use retired)	n ng most of working	16t	p. Kind of Business/	Industry
ind 212 be filed with tal Hygiene. d other than event, than		College (1-4or 5+)	Cor	1struction 18.	Mother's Name (Fin	est, Middle, Mai	den Sumame)	uction.
Maryland of 2 should be file thand Menhall Hy traumatic event	19a Informant' Name/Relations		50 S	R iling Address (Street and	Number or Rural Ro	ute Number, Ci	ity or Town, State, Z	Tip Code) 2122
ore, M	20a. Method of Disposition 1 Burial 2 Ocermation		20b. Place of Dis cemetery, c	position (Name of omatory or other place)	Date Date	Hale	thorpe. Location - City or	MD
Baltimore, I permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.	*4 □ Donation 5 □ Other (S	pecify)	EVANSFÜ	WERAL CHAP 22. Name and Address of	EC+ 4-5-6 1 Facility BALTI	MORE.	orest Hi	11 MD
ш адела	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused the only one cause on each line.	death. Do not e	1.8	uch as cardiac or res		disease	Approximate interval Between Onset and Death
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. hyperte Due to (or as a co	onsequence of):	. otheroscl	erotica	adionas	xulo	
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exec	resulting in death) Last	c	onsequence of):					
death certification of for use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy			23d. Date of deli	very Day Year
	Part II. Other significant conditi	ons contributing to death but n	ot resulting in the	underlying cause given in	n Part I.	23e. Did tobace 1 ☐ Yes		the cause of death?
Fec The law ate has b						24a. Was an autopsy performed Yes 2	prior to c death?	topsy findings available completion of cause of 2 No
of Vital Re Physician: The this certificate ha	25. Was case referred to medical examiner? 1 X Yes 2 No	Hospital:	2 ER/Outpati	Othor	3. Place of Death (Ch 4 Nursing Home		e 6 □Other (Spec	sify)
Vision of Attending Physic redeath. Setor: After this by the funeral digital filteration: To		gation	ear) 28b. Time Injury	of 28c. Injury at Work?		Describe how is		
Division C Division C To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 Suicide 6 Could 4 Homicide determ		- At home, farm, s Specify)	street, factory, office	28f. i	ocation (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
the Hospital thin 24 hours of the Funeral onpletely filled	29a. Certifier 1 Certifyin (Check only one) 2 Medicel	g Physician: To the best of m Exeminer: On the basis of example and manner stated	amination and/or	investigation, in my opinio	on, death occurred at	the time, date	and place, and due	to the cause(s)
Tot Total	29b. Signature and title of central	ionifol	Och	29c. License nu	.M.E.		Date signed (Month	
10	30 Name and address of person	VONICA-R	11/10/10	e, Print) 11 Penn S	Street, Ba	ltimore	, Marylan	d 21201
State Registrar	HER U.D. A	32 Registrar's	Signature	facili	4			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 U [] 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yee **Physician** 12:30am ANN LIFFORD -RANCES and 2004 April /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square 5 Social Security Number 6. Sex Baltimore Hospital If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Months Hours 1 □ M 2 🔀 F 62-88 FEBRUARY JARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, It a Medical Examinant man the notified at 1 ☐ Yes 2 No MARYLAND Directo TIMORE TIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code COURTS DRIVE 212 36 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give " Year or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Şecondary (0-12) College (1-4or 5+) MANAGER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) To Be KEIBER ILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTWORE MD HRISTOPHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State EMETERY APRIL 6, 2004 PARKVILLE MIARYLAND 4 ☐ Donation 5 ☐ Other (Specify) TRRIVOCO (21. Signature of Funeral Service License 22. Name and Address of Facility CHAPEL EVANS FUNERAL 21234 PARKVILLE Vneb tions that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on eight line. Part 1. Enter the disease, or complice shock, or heart failury. List on / or e Approximate Interval Between Onset and Death Immediate Cause (Final 10 days Physician disease or condition resulting in death) Due t (or as a consequence of) /Medical Examiner moni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and ned for use as the burial-transit non-small cell lung concer or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform Yes 2 has le 2 certificate 1 Yes 25 Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: Medical Certification: To 1 Yes 2) (No 1 Unpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital Confifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatule and title of certific

State Registrar

Lifford

Souare Drive Balto, MD.

9000 Franklin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Glen Meininger, 9000 From 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 0 6 2004

		1 - State Registrar AMEND ITEM #1 1. Decedent's Name (First, Middle, Last)	State of Maryla PER PHY G830 4 KA Donetha	/06/0 Cert in	ficate of L		2. Date of De	Reg. No. 201	04 1029 3. Time of Death
Physic /Med Exam	ical	DOROTHEA 4a. Facility Name (If not institution, give s		(NHW	Location of Death	Mayor	L 24 20 4c. County of D	0.05 PM
Exam	ner		A	ENTER		BALT	IMORI		
Funera Directo		5. Social Security Number 6. Sex 213-58-0437	7. Age (In yrs	N	f Under 1 Year Ionths Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da July 20		Birthplace (State or Foreign Country) laryland
/land		10a. State 10b. County	10c. C	City, Town or Locat	ion				10d. Inside City Limits
e Mar	ctor	Maryland Baltimon	re		timore		- T		1 Yes X2 No
with th	Dire	10e. Street and Number 7223 Fairbrook Road	ı		10f. Zip Code	207		10g. Citizen of Wha	t Country?
Jeath The 23	erai		2. Was Decedent Ever in	U.S. 13. Wa		ispanic Origin? (S n, Mexican, Puert	pecify Yes or No		American Indian,
be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23s or 28s-f show event. Its Madical Examinal must be tryilled at	by Funeral Director	X1√∑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X☐No If Yes, Give Year or Dates:		es, specify Cuba	Specify:	o Rican, etc.)	Specity:	Vhite, etc. Black
72 hc	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give kin	t's Usual Occupa d of work done of NOT use retired	during most of wor	rking	16b. Kind of Busine	ess/Industry
within ene. then	дшо	Elementary/Secondary (0-12) N/A	College (1-4or 5+)	_	orial W			EMerge.	Inc
VICE YIGHT A FILE OF TH	To Be Co	17. Father's Name (First, Middle, Last) Unknown		Julia	JOI TOT W	18. Mother's Nan	ne <i>(First, Middle)</i> e Conway	Maiden Sumame)	
and Mand Mis mar	1	19a. Informant's Name/Relationship (Typ	oe, Print)	100 T				er, City or Town, Sta.	
C = 14 F		David Wamsley 20a. Method of Disposition	20h	Merge,	- The second second	180 Rums	ey Road Date	Columbia.	
ages 1		★₩ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cremateadowridg	ory or other plac	1	/30/0/		
critinole, mil. Pages 1 ar portment of Hea portant: if item		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License							, Maryland
Department of the position of		Kary He	uputer					Howe, In e, Maryla	nd 21211
Physician		23 Part 1 Enter the distriction or compliss ock, or heart lailure. List only on Immediate Cause (Final disease or condition	calons that caused the de e suse on each line. Anopi	ath. Do not enter	ncerh	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
/Medica Examine	•	resulting in death)	Due to (or as a const	equence of):	fres		1		7 days
sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a const	aquiarise of): ALMIC	Cax	diomy	noa Pri	î	0
bu, be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cons)		J	
barbu, tificate be ex ig physician as the burial	<u>a</u>		Corona	my A	Merg	Dis	ease		
death cer e attending of for use	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3 E	ctopic pregnancy other (specify)			23d. Date of Month	f delivery Day Year
ecords, P.O. law requires that the as been signed by the 2 should be detached.	þ	Parti. Other significant conditions co.	atributing to death but not r	esulting in the unde	arlying cause giv	en in Part I.		_	te to the cause of death? Probably 4 Unknown
The The page	Completed						24a. Whas auto perfo 1 ☐ Yes	psy prior prmed? deat	e autopsy findings available to completion of cause of h? Yes 2 \sum No
OT VITAL P Physician: Th rhis certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		oth Oth	00	ath (Check only		
OT Phys or this oral dir	- Y	1 Yes 2 No	28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA 28c. Injur	4 Nursing r	-	dence 6 Other (Specify)
VISION Attending r death. ector: After by the fune	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	lnjury		k? Yes 2 □ No			
UNISION OT VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, stree cify)	t, factory, office			Street and Number own, State)	or Rural Route Number,
UIV To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical (sician: To the best of my k						
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, <u>* * * 8</u>		D	a - ini	Em	RE	\$ 00	1	03-6	24-04
\/		30. Name and address of person who co	empleted cause of death (I	tem 23a) (Type, Pr	int) 300 L		yer St	reet	-115
4		DR. KISHURE	SHARM	H, Har	spor	Hospila	e cei	uez, 15	allimore
Regi	State	31. Date liled (Month, Day, Year) APR 0 6 2004	32. Registrar's Sig	mature	outs				

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10		Registrar 1. Decedent's Name (First, Middle, Last)	1	Certificate of Death	2. Date of De	10g. 10.	3. Time of Death
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Funera		5. Social Security Number 6. Sex Infant	7. Age (In yrs. las	st birthday) If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birt Min (Month, Da	h 9. Bi	rthplace (State or Foreign
Directo	r.	Usual Residence of Decedent			02 00/	25/04	occorpiana
Aarylan f show	ō	M J 10b. County		Town or Location +imoRE			10d. Inside City Limits 1 Yes 2 □ No
th the l	Funeral Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	Country?
eath wi	erai	070 30 .0 10	2. Was Decedent Ever in U.S.	2/23 13. Was Decedent of Hispanic Origin	n? (Specify Yes or No	14. Race · Am	erican Indian.
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-1 show or other traumatic event, the Medical Examinar must be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 No Specify:	Puerto Rican, etc.)	Black, Wh	
21215-0036 ad within 72 hours at rgiene for then "natural; or it, the Medical Eran		15. Decedent's Educa (Specify only highest grade		16a. Decedent's Usual Occupation (Give kind of work done during most of	of working	16b. Kind of Busines	s/Industry
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e, Mar and 2 sh lealth and m 27 is m		19a. Informant's Name/Relationship (Type TERESA CIART	4	19b. Mailing Address (Street and Number 2536 Box D	5+ 2/	223 RA	tin of E
Baltimore, permit. Pages 1 ar Department of Hea mportent: If item eny injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. Plac	ce of Disposition (Name of netery, crematory or other place)	Date	20c. Location - City o	r Town, Slate
timent riment ri		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Wood		/02/2004	Baltimore	
Department		> Edway M.	Terkins	Sterling Ashton 736 Edmondson Av	Schwab Fun e. Baltim	eral Home, ore, MD 21	1nc. 228
3		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	ations that caused the death. cause on each line.	Do not enter the mode of dying, such as co	ardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
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Division of Attention after death I Director:	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, elc. (Specify)	e, farm, street, factory, office	281. Location (S City or Tov	Street and Number or F vn, State)	Rural Route Number,
Divi	edical C			edge, death occurred at the time, date and in and/or investigation, in my opinion, death			
To the within 2 To the comple	Med	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mor	nth, Day, Year)
		Naomi		b		3 25 04	
		30. Name and address of person who con	npleted cause of death (Item 2	St Paul Pla	ce Bul	+. MD ?	21202
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	- / 4 / / /	•		
© Regi		APR 0 6 2004	Janes A.	Agosaki !			
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			1 - For Amend Items 24a,25 Registrar	5,27 per Dr.	yland / Der ,G830,04/26	partment of F Outline Prifficate of	lealth and M <i>Death</i>	lental Hyg	giene Reg. No. 200	4 1020
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	Physici /Medio		John H. Combs					Februar		
je.	Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	
			418 Freedom Lan				de Grace		Harf	ord
t	Funeral Director		5. Social Security Number 6. Sex 15 Usual Residence of Decedent	7. Age	In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9. Bir	rthplace (State or Foreign ountry) unk
	land ow		10a. State 10b. County		Oc. City, Town or L	ocation				10d. Inside City Limits
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920	d within 72 hours after death with the Maryland piene. I than "natural", or Items 23a or 28a-1 show It a Medical Exercit per relation at	by Funeral	11. Marital Status Unik. 1 Never Married 2 Married 3 Widowed 4 Divorced	I2. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13 unk	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
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yland	should be filed and Mental Hygi s marked other umatic event, I	To Be	17. Father's Name (First, Middle, Last)			unk	18. Mother's Name	e (First, Middle, i	Maiden Sumame)	unk
	s 1 and 2 should be filed if Health and Mental Hyg item 27 is marked otha other traumatic event,		19a. Informant's Name/Relationship (Tyr Diane Lawder/MEO	oe, Print)	19b. Mail	ing Address (Street	and Number or Rura	al Route Number	, City or Town, State, a	Zip Code) unk
Baltimore,	Page nent o ant: # ury or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Ri '4 □ Donation 5 🕅 Other (Specify)	in state	20b. Place of Disp cemetery, cre	osition (Name of imatory or other plac	(e)	Date	20c. Location - City or	Town, State
Bal	permit. Departr Imports any inji		21. Signal to of Euneral Service License Ronald S	1100	ctor B	arcamore,	omy Board MD 2120	1	Baltimore	Street
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Division of	r Attender death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (· At home, farm, st		/es 2 □ No 2	8f. Location (Sti	reet and Number or Ru	ral Route Number,
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)	To Con	<	29b. Signature and title of certifier	1/2	210	29c. License		29	Od. Date signed (Month	i, Day, Year)
			Jeorge 1	premy	44	100	6547		2/7/2	004
			30. Name and address of berson who cor GEORGE K. H. 31. Date filed (Month, Day, Year)	ENRY M- 32 Registrar's	n - 6	Print) S. Cu	rion Al	E. H	rupe de 6	Face Old.
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		1- For State of Maryland / Depar Registrar Certif	tment of Health and Mificate of Death	lental Hygien	
Physi /Med	dical	1. Decedent's Name (First, Middle, Last) Phillip James Clayton 4a. Facility Name (If not institution, give street and number)	Ib. City Town and continue of Doub	April 3,	
Funera	al	12005 Taragon Road Apt D 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 12005 Taragon Road Apt D 5. Social Security Number	Reisterstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		
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death with the Maryland ms 23a or 28a-f show rmust be notified at	ai Director	MD Baltimore Reisters 10e. Street and Number 12005 Taragon Road Apt D	stown 10f. Zip Code 21136	10g. C	itizen of What Country?
5-UU30 72 hours after des natural; or Items	1 by Funeral	1 Never Married 2 Married 1 Yes 2 ZNo	s Decedent of Hispanic Origin? (Spe es, specify Cuban, Mexican, Puerto I] Yes 2 🖾 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
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should be file and Mental Hy marked other	To Be (17. Father's Name (First, Middle, Last) Horace L. Clayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	18. Mother's Name Helen Standards (Street and Number or Rura		
DESILITIONE, METYIERIG Z.I.Z.I.D-UU.SO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examt with must be multical at		Olivia Keels Daughter 3700 E 20a. Method of Disposition 20b. Place of Disposition 1 □ Burial XXXCremation 3 □ Removal from State	1mona Avenue Bala on (Name of ory or other place)	timore MD ate 20c.L	21213 .ocation - City or Town, State
Definit. Pages Department of Important: if if if any injury or or or or or or or or or or or or or	5000	21. Signature of Funeral Service Oceasee 22. N	ne Funeral Home I	l1824 Reis Reistersto	terstown Road
Physiciar /Medica		23). Part 1. Enter the disease, or complications that caused the death. Do not enter to sheek, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	he mode of dying, such as cardiac or	r respiratory arrest,	Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events resulting in death) Last Due to (or as a consequent. I f): Due to (or as a consequent. I f): C. Due to or as a consequence of):	den diser noliher II nose		
wrequires that the death certifical been signed by the attending phe should be detached for use as the	Physician/Medical		topic pregnancy ther (specify)		23d. Date of delivery Month Day Year
requires that requires signed be required be deta	b	Part II. Other significent conditions contributing to death but not resulting in the und	rlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
vital necessician: The law is certificate has birector, page 2 st	e Completed	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed? 1 Yes 2 No.	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
ding Physician. After this certioneral direct	ion: To B	27. Manner of Deal 28a. Date of Injury 28b. Time of Injury (Month, Day Year) 28b. Time of Injury	3 DOA Other: 4 Nursing Hom 28c. Injury at Work?	ne 5 Residence 8d. Describe how inju	
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	M 1 Yes 2 No	8f. Location (Street ar City or Town, State	nd Number or Rural Route Number, a)
o the Hospi ithin 24 hou o the Funer ompletely fill	Medicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death or control one) Certifying Physician: To the best of my knowledge, death or certifier and manner stated.	curred at the time, date and place, and addition, in my opinion, death occurred 29c. License number	d at the time, date and	and manner as stated. d place, and due to the cause(s) te signed (Month, Day, Year)
+ 3 F 8/		30. Name and address of person who completed cause of death/(Item 23a) (Type, Plus	D3181	10000	4-5-04
S' Regis	tate trar	31. Date filed (Month, Day, Year) APR 0 6 2004 32. Registrar's Signature	e 100 13/12-10	W16) 2	NUUS

	<u> </u>		For State Registrar	State of	Maryland / De	partment ertificate			nd Mental		0.0	04	102	95
	Physici	an	Decedent's Name (First, Middle,	,	D				2. Date of		Day	Year	3. Time of D	
	/Medic	al	4a, Facility Name (If not institution,	th Jerome		4b. City, T	own or l	ocation of	APR	<u> </u>	2, 20 4c. County	004	9:56 J	<u>)</u>
4	Examin	er	1914 Beverly Ro		55.7			nsvil.				11tim	ore	
	Funeral		5. Social Security Number 6	3. Sex 7 ≯□ M 2□ F	. Age (In yrs. last birthd	Months		If Under 24	Hrs. 8. Date of	f Birth	1915	9. Birthp	place (State or i	Foreign
	Director		294-01-8679 Usual Residence of Decedent	¥EJM 2LIF	89 Yrs				FEB	9,	1915	0.	nio	
	land ow		10a. State 10b. County		10c. City, Town or	Location						1	0d. Inside City	Limits
	Mary Pefsh	tor	Maryland Bal	timore		Cato	nsvi	11e					1 ☐ Yes 2	2X No
	iff the	Oirec	10e. Street and Number			10f. Zip 0				10g.	Citizen of W		ntry?	
	death with the Maryland ims 23a or 28e-f show	ral	1914 Beverly R					.228			14.5	USA		
	her de fram	Funeral Directo	11. Marital Status1 ☐ Never Married 2 ☐ Marrie	Armed For	dent Ever in U.S. 1 ces? 2 □ No			Mexican,	n? (Specify Yes o Puerto Rican, etc	r No- .)		k, White,	an Indian, etc.	
036	72 hours after natural', or Ite	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Da	•	1 ☐ Yes 2	∆ No	Specify:			Specify:	W	hite	
21215-0036	72 ho 'natur	Completed	15. Decedent's (Specify only highest		16a. De	cedent's Usual ive kind of work e. DO NOT use	Occupation done dur	on ning most o	of working		o. Kind of Bu		,	
121	e filed within al Hygiene. I other than " vent, I to Wes	duc	Elementary/Secondary (0-12)	College (1- 5+	40(5+)	storian				FE	US An		ernment	. –
	Hygi Hygi other	0	17. Father's Name (First, Middle, La			S COL LOI		8. Mother	s Name (First, Mi	ddle, Mai				
/lar	should be nd Mental marked c	To B	Robert Edward D	eacon				C1	lara A.	B. Du	ıckwit:	Z		
Maryland	01 (0) (0)		19a. Informant's Name/Relationshi						or Rural Route N			State, Zip	Code)	
e,	1 and Health em 27		Madeleine C. Bea 20a. Method of Disposition	rd/daught	20h Place of Di	08 Rices sposition (Name	0.06		delphi, I	-) /83 :. Location - (City or To	wn. State	
Jou			1 Burial 2 XCremation 3		tate Metro C	crematory or oth	ner place)	nc d	4/5/04			•	re, MD	
Baltimore,	permit. Page Department of Importent: if any injury or once.		21. Signature (Funeral S e	magn	nald	Cremati	Address	8 65 181	y of Ma				20	
			23a, Part1, Enter the disease, or c	CDona10 omplications that ca	used the death. Do not				oad Bal		ce, MD	212.	Approximate	
	Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition		elumina								Onset and De	
	/Medical Examiner		resulting in death)	Due to (c	or as a consequence of):								- 2-9	>
10	Examine	-	Sequentially list conditions,	b. — Due to (c	or as a consequence of):									
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	5001010	as a solidoquellos dif.									
o,	certificate be executed iding physician and use as the burial-transit		that initiated events resulting in death) Last	Due to (c	or as a consequence of):									
8760	ate be ei hysician he buria	icai	•	d										
9	certifica nding ph use as t	/Med	IF FEMALE:	220 Marga auto	ama of avanage.									
Вох	atter for u	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir		3 □Ectopic pre					23d. Date Mon		ery Day Ye	ar
0.	at the de by the tached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno										
s, P	an the	ру Р	Part II. Other significant condition Postste C	s contributing to dea	ath but not resulting in th	e underlying cau	use given	in Part I.	İ				e cause of dea	
ord	w require been sig should t	sted	FA. Cure to	Has is					_	Yes	2 1 No	3 🗌 Prob	ably 4 □Un	known
3ec	has has	Completed	- Alune To	0,,,,,4						Mas an autopsy performed	DI	ere auto rior to cor eath?	psy findings av npletion of cau	allable use of
la		e Co	25. Was case referred to medical					OF Blood of	1 ☐ Y	es 2			2 No	
Ι	Physicien: this certific ral director,	0 8	examiner? 1 🗆 Yes 2 📉 No	Hospital: 1 🔲 In	patient 2 ER/Outpa	tient 3 DOA			ing Home 5X		e 6 🗆 Othe	r (Specifi	()	
Division of Vital Records,	ding Phys n. After this funeral di	J:uo	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month)	Injury 28b. Time , Day Year) Injur	e of 28	c. Injury a Work?	it			njury occurre			
Sio	Attending r death. sctor: After by the funer	icati	2 Accident investiga 3 Suicide 6 Could no	t he	- Albana fara	M		s 2 No		(Ct	A moral Alcombin	0	1 Davida Streets	
Divi	after of Direct of Direct of Jin by	Certification:	4 Homicide determin	ed 286. Place of buildin	of Injury - At home, farm, g, etc. (Specify)	street, factory,	OTICE			Town, S		ir or Hura	l Route Numbe	31,
	lospitel or hours afte unerel Dir	aic	29a. Certifier 1 Certifying	Physician: To the I	pest of my knowledge, de	eath occurred at	t the time,	, date and	place, and due to	the caus	e(s) and man	ner as st	ated.	
	the H in 24 the F the F	ledicai	one)	and manni	sis of examination and/o er stated.				occurred at the t					
	To To Con	Σ	29b. Signature and title of certifier	The	2/5	29c.	License n	rumper		29d.	Date signed	(Month,	2004	,
	di		30. Name and address of person w	ho completed cause	of death (Item 23a) (Tvi	pe, Print)	1	21	_/	1	1	1		
_	10		EDMUND (Moor	uk 405	Bellend	h K	d to	whe low) Ca	minera	161 1	4D 210	228
	Sta		31. Date filed (Month, Day, Year) APR 6 2004		1									
	Registr	(d)	AFR U LOU4	were	10	park	/_		·					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician isnec 2004 /Medical 4c. County of Death
BAUTIMOR 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PARKVILL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 2-27-0 6. Sex **Funeral** 1□M 200 F 3 Yrs. **Director** Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits , or Items 23e or 28e-f show the Mudical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director HUTIMORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2123 Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify. Specify: Completed by 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education pecify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, If a Mule 2006. College (1-4or 5+) Elementary/Secondary (0-12) 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be therman Koush, Ox ပ KO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Info the nt's Name/Relationship (Type, Print) \mathcal{C} 20b. Place of Disposition (Name of 20a. Method of Disposition

1 a Burial 2 ☐ Cremation Date 3 ☐Removal from State acility BALT, more mo *4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service t CHAPEL, 8800 HARFORD RD. 23a. Part1. Enter the disease or complication s that cause, the de th. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each h.e. Approximate Interval Between Onset and Death shock, or heart failure. I Immediate Cause (Fi al disease or condition resulting in death) Pnysician nani 2 months /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lieuward of Lieuward) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9☐ Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0034650

Registrar

State

31. Date filed (Month, Day, Year)

ress of person who completed cause of death (Item 23a) (Type, Print)

MD

9712

32. Registrar's Signature

			For Stata Registrar	State of Ma		partment of ertificate o	Health and f Death		giene Reg. No. 2004	10297
			1. Decedent's Name (First, Middle,	Last)				2. Date of De	aath	3. Time of Death
	Physici /Medio		Susann	D.		Dreyfu	IS	Month 2/	Day Year 200	4 3:10 P M
	Examir		4a. Facility Name (If not institution,	give street and number)	<i>T</i> /	4b. City, Town	, or Location of Dea	th	4c. County of Dea	
			FRANKlin Sel	JARE HOS	pilAl	Rosa			BAITI	MORE
	Funeral		, ,	6. Sex 7. Ag 1 ☐ M 2 💢 F	e (In yrs. last birthd 60 Yrs	Months Day			th 9. Bir	thplace (State or Foreign ountry)
	Director		217–40–6365 Usual Residence of Decedent	10.111.2.2	60 Yrs	•		April 2	0,1943 N	D.
	and		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	Mary 1 sh	ō	MD. Baltin	more	Rose	edale				1 ☐ Yes 2 X No
	ours after death with the Marylan rai', or itams 23e or 28e-f show Examinar must be notified at	Director	10e. Street and Number		l	10f. Zip Code	9		10g. Citizen of What C	ountry?
	30 oi	Ē	5717 Hamilton A	venue		21	237		USA	
	deatl	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S.	3. Was Decedent of	of Hispanic Origin? (Suban, Mexican, Pue	Specify Yes or No	14. Race - Am	
ပ္	or its	F	1 ☐ Never Married 2 X Marrie	Armed Forces? ad 1 ☐ Yes 2 ☐ X If Yes, Give	No	1 Tes, specify C		no mican, etc.)	Black, Whi Specify: Wh	
93	72 hours after death with the Maryland natural', or itams 23e or 28e-1 show dical Examinat must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:					Specify: VVII	
21215-0036	I within 72 hours jiene. r then "natural", he wedital Ex-	Completed	15. Decedent' (Specify only highest		16a. De	cedent's Usual Occive kind of work do	cupation ne during most of wo ired)	orking	16b. Kind of Business	/Industry
121	within lene. then "	фш	Elementary/Secondary (0-12)	College (1-4or 5)+)		,		D-1+:	Q
2			10 Years 17. Father's Name (First, Middle, L	ast)	Nucr	itionist	/ Aging	me (First, Middle,	Baltimore Maiden Sumame)	county
an	ould be Mental larked o	o Be	John E. Wheatle					or Huth	,,	
Maryland	# DEF	၉	19a. Informant's Name/Relationsh		19b. M	ailing Address (Stre			er, City or Town, State,	Zip Code)
	2 = 21 -		Joseph Dreyfus	Husband					le, Md. 212	
Baltimore,	es 1 an of Heell fitem 2 r other		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other p	nlace) Any	pate 7,	20c. Location - City or	Town, State
E	Pages nent of int: if it		1 Burial 2 □ Cremation 1 □ Donation 5 □ Other (Sp		1	n Cemeter			Dundalk, MD	
atti	permit. Pag Department important: i any injury o		21. Signature of Funeral Service L	icensee	00	22. Name and Add	dress of Facility			
<u>m</u>	\$ 2 E E 9		MITHON	1-6-0	nvelley	7110 Sol	lers Poir	t Road,	Dundalk,P. Dundalk,MD	21222
			23a. Part1. Enter the disease, or shock, or heart failure. List	omplications that caused nly one cause on each lie	the death. Do not	enter the mode of d	lying, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Physician	l n	Immediate Cause (Final disease or condition	Acute		toniti	5			Onset and Death
	/Medical		resulting in death)		a consequence of):			1.	r	
	Examiner		Sequentially list conditions,	b. BUPT	ured	Sigmoi	d Dive	Cticy	lym	
	ed sit	ine	Sequential / list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):	0				
	and and II-trar	Examine	that initiated events resulting in death) Last	c Due to (or as	a consequence of);					
8760	The law requires that the death certificate be executed the bas been signed by the attending physician and page 2 should be detached for use as the burial-transit			<u>`</u>	, , , ,					
687	ficate physics the	Physician/Medical		0.						-
Вох	eath certific attending p for use as f	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		_			23d. Date of de	livery
m	death s atte d for	icia	in the past 12 months?	4☐Pregnant at		3 □Ectopic pregnar 5 □ Other (specify)			Month	Day Year
0.	that the dended by the a	hys	9 Unknown	9L Unknown						
В, Р	es tha igned be del	by P	Part II. Other significant condition	s contributing to death b	ut not resulting in th	e underlying cause	given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
ıd	w require been sig should b							1 🗆 1	Yes 2 □ No 3 □ Pi	obably 4 Unknown
Records,	law ri as be 2 shi	ompleted						24a. Was		utopsy findings available completion of cause of
<u> </u>		Con						perfo	rmed? death? 2☐No 1☐Yes	
Vital	Efficiency or a	Be (25. Was case referred to medical examiner?					ath (Check only o	one)	
of \	Physicia this cer al direct	은	1 Yes 2 No	Hospital:		tient 3 DOA			dence 6 Other (Spe	cily)
	ing After une	ion	27. Manner of Death 1 Natural 5 ☐ Pending		ry y Year) 28b. Tim Inju	y W	jury at /ork? □Yes 2□No	28d. Describe h	how injury occurred	
isio	tend death tor: the	icat	2 Accident investigation 3 □ Suicide 6 □ Could no	ot be Ose Place of Ini	ury - At home, farm,			28f Location /9	Street and Number or Ri	iral Boute Number
Division	o after	Certification:	4 Homicide determin	building, et	c. (Specify)	stroot, ractory, onic	d	City or Tou		TAI HOULE HUILDEN,
_	spite ours nerei		29a. Certifier Certifying	Physician: To the best	of my knowledge, de	eath occurred at the	time, date and place	e, and due to the	cause(s) and manner as	s stated.
	To the Hospitei within 24 hours a To the Funerei completely filled	edical	(Check only 2 Medical E	xaminer: On the basis of and manner sta	f examination and/o ated.	r investigation, in my	y opinion, death occ	urred at the time,	date and place, and due	to the cause(s)
	To the vithin 2 To the complet	Σ	29b. Signature and title of certifier	7/		29c. Lice	nse number		29d. Date signed (Mont	h, Day, Year)
	ili) Wel	le mo		Re	0000		4-2-20	104
	12		30. Name and address of person w	no completed cause of d	eath (Item 23a) (Ty	oe, Print)	۸ ۰	1	,,,,,	7
			DRI KOGER HA 31. Date filed (Month, Day, Year)	N 4000 FX	AUKLIN	SQUARE	DR. BA	Himok	E Md 2	1237
	Sta Registi		APR 0 6 2	004	J. J. A	sele			4-2- 20 1E Md 2	

SusAun DReytus

		1 - For State Registrar	State of Man	•	epartment of I Dertificate of		R	eg. No. 2	004	10298
Physici /Medio		1. Decedent's Name (First, Middle, Las Wallace S. 1					2. Date of Dear Month APPLL	Say 5	2004 C	3. Time of Death D650 M
Examir		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death	1	4c. Coun	ty of Death	
		Frederick Villa				sville	0.0		ltimore	
Funeral Director		5. Social Security Number 6. Security Number 161-12-4589	T	In yrs. last birtho	Months Days		8. Date of Birth (Month, Day, Dec 18,	Year)	9. Birthplace Country) Illino	e (State or Foreign
e-f show		10a. State 10b. County	10	Oc. City, Town o	or Location				10d.	Inside City Limits
	Ď	Maryland Baltimo:	re	Caton	sville					1 ☐ Yes 2X No
d within 72 hours after death wirfthe Marylan sjene. Than 'natural', or Iteme 23a or 28e-1 ehow the Mad cal Examiner must be nutilized at	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Country?	7
		9 Walden Mill Wa	ay		2	1228		U.S	S.A.	
25 F	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No- p Rican, etc.)		ace - American I	ndian,
s afte	by Fu	1 ☐ Never Mamied 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give W	W II	1 ☐ Yes 2 ₺ No			Spec	ify: TTL 4	
72 hours after natural', or its	ed b	15. Decedent's Ed	Year or Dates:	16a D	ecedent's Usual Occu	pation		16h Kind of	"White Business/Industr	
in 72 n na neolic	Completed	(Specify only highest grad	de completed)	1 (0	Give kind of work done fe. DO NOT use retire	during most of work	king	TOD. TUITO OF	203111033411100311	17
e filed within all Hygiene. other than "r	E	Elementary/Secondary (0-12)	College (1-4or 5+) 4	A	dministrat	or		Social	Securi	ty
othe othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, I	Maiden Suma	ime)	
should be find Mental H marked of	To	Raymond Reed Doole	e у			Edna Su	mmers			
and is ma		19a. Informant's Name/Relationship (7	'ype, Print)	19b. M	failing Address (Street	and Number or Ru	ral Route Number	City or Town	n, State, Zip Coo	de)
s 1 and 2 should be filed if Health and Mental Hyg Item 27 is marked othe other treumatic event,		William Dooley	(Son)		l Briarcli		Baltimor			
Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of D cemetery,	isposition (Name of crematory or other pla	ce)	Date	20c. Location	- City or Town,	State
permit. Pages Department of Importent: If it any injury or o		' 4 □ Donation 5 □ Other (Specify	·	Garris	on Forest					Maryland
permit. Pages Department of Importent: If It any injury or o		21. Signature of Funeral Service Licen	500	0:2	Witzke Fu	ess of Facility neral Hom	e of Cat	onsvil	le, Inc	
40340		23a. Part1. Enter the disease, or comp	lications that caused th	e death. Do not	1030 Edino	ndson Ave	nue Cato	nsvill	e, Mary	rland ∠1∠∠
		shock, or heart failure. List only	one cause on each line.			ng, such as cardiac	or respiratory arre	351,	Inte	erval Between iset and Death
Physician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	a. RESPIRATE Due to (or as a c	RY FA	ILURE				11	MONTH
Examiner						í				
	-e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ASPINATI	onsequence of)	EUNCUM					
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· ORUPITAL	RYNGH	M. DYSP	HABIA				
be executed icien and burial-transit		resulting in death) Last	Due to (or as a c	onsequence of)	:	,,,,,,,				
ysicie	cal		d. LATE EF	FECT .	STROKE					
certificate nding phys	Med	IF FEMALE:								
w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Physician/Medic	23b. Was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 [Fetal death	3 ☐Ectopic pregnanc	у			ate of delivery lonth Day	/ Year
e death the atten	Sici	in the past 12 months?	4☐ Pregnant at tim 9☐ Unknown	ne of death	5 Other (specify)			l M	onth Day	real
that the ed by th detache	Phy	9 Unknown Part II. Other significant conditions or	natributing to double but a	nat roovilting in th	a vadadina asusa su	ven in Don't	230 Did tob	2222 1122 227	ntribute to the ca	auga of death?
res th	by	Part II. Other significant conditions co	milibuting to death but h	iot resulting in ti	ie underlying cause gr	ven in Fanti.				4 Denknown
requires been sign hould be	eted									
e 2 sh	ompieted						24a. Was a autops perform	v l	. Were autopsy f prior to comple death?	findings available etion of cause of
: The cate has	S						1 ☐ Yes 2		1 Yes 2	LH6
Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		Ott	1	th (Check only on			
hys this al di	-To	1 Yes 2 No 27. Manner of Death	1 Inpatient	2 ER/Outpa	atient 3 DOA	4 Nursing H	ome 5 Reside			
g e e	tou	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) Inju	ıry ₩o	rk? Yes 2 □ No		".iai y ooda		
for Attending after death. Director: Alter in by the fune	fica	3 Suicide 6 Could not be		- At home, farm	, street, factory, office		28f. Location (St.	reet and Num	ber or Rural Ro	ute Number,
after Dire	Certification:	4 - Homicide	building, etc. (Specify)	,,,,,,		City or Town			
To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	a C		ysician: To the best of n							
e Ho 1 24 h	edicai	(Check only 2 Medical Exam	niner: On the basis of ex and manner stated	amination and/o	or investigation, in my	opinion, death occur	red at the time, da	ate and place	, and due to the	cause(s)
To th Withir To th comp	M	29b. Signature and title of certifier	7		29c. Licens	_	25	9d. Date sign	ed (Month, Day,	Year)
1.		Melva 4 X	un		1445		/	APRIL	5, 2004	f
M		30. Name and address of person who		h (Item 23a) (Ty	OMPUCHEL			The second		1.0.63
		Leberah I P	terce 7		DAIUL HEIG	SHTS AVE	NUE 1	SALTIN	WIE N	40 2 BUS
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's		1 .					

			State of Maryland / Department of Health and Messate Amend Item 5 per FH, G830,04/13/04dhb Certificate of Death	ental Hygie	ne 2001. 10000
	Physicia	an			No. 2 U U U 1 1 2 Q Q Day Year 9:00 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death FIXED A	APRIL	4c-County of Death
	Funeral Director		5 Social Socurity Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 407 300 407 70 1 M 2 9 F Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	show	٥٢	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 [☐ Yes 2 ☑ No
	death with the Maryland ima 23a or 28a-f show	Directo	10e. Street and Number 10f. Zip Code 2001	10g.	Citizen of What Country?
	be filed within 72 hours after death with the Marylan at all typiene. All Hypiene. All Hypiene. Saent. In Medical Exaction mater to relified at svent.	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 1 Yes 2 No	cify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	72 hours atter natural; or Ita	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 1 Never Married 2 Married 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Specify: 1 Give kind of work done during most of working.	166	Specify: WhiTE D. Kind of Business/Industry
	filed within 7 Hygiene. other then "r ant, the Miss	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	C	EUN HOME
Maryland	2 should be fill and Mental H Is marked oth aumatic sven	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (MARY)	SMITI	h
-	5 5 5 5 d			LKTON, A	
nore	Pages 1 ar nent of Hea int: If item iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	104 Ha	Location - City or Town, State
Baltimore	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Dicensee 22. Name and Address of Facility DAU AND CREMATION CENTER 22. Name and Address of Facility DAU AND CREMATION CENTER 24. MRCUATAIN SOLUTION 25. MRCUATAIN SOLUTION 26. MRCUATAIN SOLUTION 26. MRCUATAIN SOLUTION 26. MRCUATAIN SOLUTION 27. MRCUATA	P.A.	MILY TWENDHOME
	Physician		23a. Part . Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Metastatic Breast Curcus Curcus The state of the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,	Approximate Interval Between Onset and Death
· · · · · · · · · · · · · · · · · · ·	/Medical Examiner		Due to (or as a consequence of):		
-54	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.		
8760,	cate be executed bhysicien and the burial-transit	icai Exa	resulting in death) Last Due to (or as a consequence of): d.		
Box 68	death certifica le attending ph ad for use as th	n/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
P.O. B	0 0 0	Physician/Med	in the past 12 mopths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
	sign sign d be	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Records,	The ate h page	Completed		24a. Was an autopsy performed	
Vita	sician: certific rector.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home		6 □Other (Specify)
Division of Vital	Attending Physic death. sector: After this by the funeral di		The state of the s	3d. Describe how in	
Divis	al or Attendi s after death. Il Director: A id in by the fu	Certification:	a Clarity 6 Claud not be	Bf. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely tilled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and place and	nd due to the cause d at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To t withi To t	X	29b. Signature and title of certifier 29c. License number		Date signed (Month, Day, Year)
	1		032633		7 /2/09
	V		30. Name and address of person who co belied cause of death (Item 23a) (Type, Print) Martha Hasterd - Skaper, md III W. High St	t. Stel	104 Elkton, MD

State of Maryland / Department of Health and Mental Hygiene $200\,\mathrm{L}$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Frances Dill Month March 31, 2004 ear 3:40 a. **Physician** /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Olney Montgomery Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign
Country) **Funeral** Days 1 □ M 2 X F 79 213-20-7726 Director November 5, 1924 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-1 show event, the Medical Examinar must be notified at 1 Yes 2 No Maryland Dayton Howard Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant.: If ten 27 is marked other than "naturet", or items 23a or : ury or other traumatic event, Ita healting Exam an Immater. 21036 U.S.A. 4710 Linthicum Rd. Completed by Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify: 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Cafeteria Elementary/Secondary (0-12) College (1-4or 5+) School Cafeteria 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Helen O'Neal Thomas Frederick Blaney 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7618 Patapsco Drive Sykesville, Maryland 21784 Ms. Patricia Ireland Neice 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation Services, Inc. 04/01/2004 Sykesville, Maryland 4 Donation 22. Name and Address of Facility
Slack Funeral Home, P.A M0129 3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. as cardiac or respiratory arrest, Immediate Cause (Final disease or condition myocarvial Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last oronan Due to (or as a consequence of); Physiclan/Medicai Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 Yoo 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy ŏ Day Year 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably al nommer es 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 No 2 No 1 Tyes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No Impatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27 Manner of Death 28b Time of 28d. Describe how injury occurred Certification: Division 5 Pendina 1 Natural To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certific 29c. License number 29th Date signed (Month, Day, Year) Conar ss of person who completed cause of eath (Tem 23a) (Type, Print) EXECUTIVE BIVO, FOCKUTTLE 111) Ronard 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		-	For State Registrar	State of Maryland / D	•	rtment of He tificate of D				ene 9. No. 200	4 10301
	Physicia		1. Decedent's Name (First, Middle, Last) John R. Ensor	-					Date of Death	3	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, or	Location o	of Death		4c. County of De	
	Funeral		Anne Arundel Medic 5. Social Security Number 6. Sex 12 - 07 - 3076	7. Age (In yrs. last birth	hday) (rs.	Annapoli: If Under 1 Year Months Days	S, Ma If Under: Hours	24 Hrs. 8 Min.	. Date of Birth (Month, Day,	Anne Aru	rthplace (State or Foreign Country)
	Director	-	Usual Residence of Decedent		ris.			M	arch 20	, 1919∣ Ba	ltimore, MD
	Maryland a-f show lied at	tor	10a. State 10b. County Maryland Anne Arun	del Pasaden		ation					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28¢	Director	10e. Street and Number	•		10f. Zip Code			10	og. Citizen of What C	Country?
	e 23e		852 Swift Road	2. Was Decedent Ever in U.S.	13 V	21122 Vas Decedent of His	enanic Ori	nin? (Specif	fy Ves or No-	USA 14. Race - Am	neocan Indian
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or items 23s or 28s-f show aumatic event, the Medical Exactiver must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 🗖 Widowed 4 Divorced	Armed Forces? I Tyes 2 No If Yes, Give WW I I Year or Dates:	If	Yes, specify Cubar	Specify:	, Puerto Rio	can, etc.)	Black, Wh	ite, etc.
Maryland 21215-0036	hin 72 hou e. en "natura Medical E	Completed	15. Decedent's Educa (Specify only highest grade	completed) College (1-4or 5+)	(Give I life. D	ent's Usual Occupa kind of work done d O NOT use retired)	uring most	t of working		16b. Kind of Busines	
2	filed wit Hygiene Sther the		6	Horr	ne I	mprovemen		rl= \$10 == //		Constructi Maiden Sumame)	ion
yland	ould be fil Mental H Marked otl	To Be	17. Father's Name (First, Middle, Last) Thomas Ensor				Jes	sie Ü	nknown		
, Mar	and 2 sh ealth and n 27 is m			on) 85	52 S	wift Road		saden	a, MD 2		
Sore	ages 1 nt of H i if iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State cemeters	y, crem	sition (Name of eatory or other place		Dat		20c. Location - City o	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic evones.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of June 11 Service (Centre)		22.	Name and Addres	s of Facilit	y Sta	llings	Funeral H na, MD 211	
	#5 ⁵		23a. Part1. Enter the disease, or complication	ation that caused the death. Do n							Approximate Interval Between
	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	Chronic a	Pui	tructure	Pul	mano	nu d	Line	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of	of):	o se specie	1	1	1	4111	
	44	e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	of):						
	cuted nd ransit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.								
8760,	icate be executed physicien and s the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequence of	of):						
687	physicate physics the	edicai	d.								
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be delached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)				23d. Date of di Month	elivery Day Year
α.	that the de led by the a detached t	/ Phy	Part II. Other significant conditions cont	ributing to death but not resulting in	the un	derlying cause give	n in Part I.		23e. Did tob	acco use contribute	to the cause of death?
rds	w requires been sign should be	ed by							1 □ Ye	s 2□No 3□F	Probably 4 Unknown
Division of Vital Records,	The law requate has been page 2 shoul	Completed			_				24a. Was ar autopsy perform 1 Yes 2	y prior to	
/ita	Physician: The lathis certificate harral director, page	Be	25. Was case referred to medical examiner?	spital:		Othe		of Death (Check only one	9)	
of	두 등 교	1: To	1 Yes 2 No	28a. Date of Injury 28h. T		28c. Injury	at Nu			nce 6 Other (Sp w injury occurred	ecify)
sion	ttending F death. ctor: After y the funera	ation	1 Natural 5 Pending investigation	(Month, Day Year) Ir	njury	M 1 □ Y	? ′es 2 □ I	No			
DIX	or A offer Direction by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, stre	eet, factory, office		28	f. Location (Str City or Town	reet and Number or F , State)	Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical		cian: To the best of my knowledge er: On the basis of examination and and manner stated.							
)	To the To the comp	Σ	29b. Signature and title of certifier			D 3		8		9d. Date signed (Mor 4/2/04	
	let 1		30. Name and address of person who com	ppleted cause of death (Item 23a) (Type,	Anna foli	7 10	load :	#106	odent	EU MD21113

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month . **Physician** :35/1 2004 John E. Erhardt /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4d. County of Death Examiner nar 162 Himore atonsville Hours Min. 8. Date of Birth (Month, Day, July 2, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1⊠ M 2□ F 92 212-09-7970 Yrs. Director New York Usue! Residence of Decedent death with the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylen ment of Health end Mentel Hygiene.
ant: if Item 27 is marked other than "naturel", or itema 23a or 28a-f ehow ury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director |Maryland Baltimore Catonsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1319 Gatefield Road 21228 U.S.A. Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ð 3[™] Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 11 Engineer Stee1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John E. Erhardt Martha Ruhlemann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Mears (Daughter) 1317 Gatefield Road Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I Important: If Ite any Injury or of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 4-6-2004 Baltimore, Maryland 21. Signature of Funeral Service Livens 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, MD 21228 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical neimer Examiner Due to (or as a consequence of): Physician/Medical Examiner physician end s the buriel-trensit To the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760. Due to (or as a consequence of): been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 10 0 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No М death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature end titl® 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and eddress completed cause of death (Item 23a) (Type, Print) 31. Dete filed (Month, Day, Vear) 32. Registrer's Signature State APR 0 6 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2001 10303 For State AMEND ITEM #8 PER FH G830 4/06/04 JE ertificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 1:15 141 Helen B. EVANS 04 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE Ad. BON SECOURS HOSpital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 XF 79 APRIL 20,1924 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b County r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at MD 1 Xes 2 No Baltimore **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Monticello Road death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Ite ury or other traumatic event, the Medical Examinal 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK Be Completed by 3 ☐ Widowed 4 MDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) SOCIALSECURITY CLERK 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EDWARD JONES BLANCHE DIGGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4010 Edmondson Avenue Baltimore MD 212 NYLA R. WALTERS Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Locetion - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS Ballo. 4 Donation 5 Other (Specify) 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SCRVICES 21. Signature of Funeral Service Licen (8) and 5151 BALTIMORE NATIONAL PIKE BALTIMORE ND 21720 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final sephie Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Nega Gram Savuer traily list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequent of) Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or a* a consequence of) Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by LEUK 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 2 No seare the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 DOA 2 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier . SANDHU DHYSIGAN D 57543 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLUP, BALTIMORE MD 21230 SANDHU MP 700, WAJHINGTON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 0 6 2004

			1 - For State Registrar AMEND ITEM	State	f Manular	nd / Don	artmont o	of LL	a alth .	and A	fental Hyg	iene	2004	i loani
	Div t-:		1. Decedent's Name (First, Middle								2. Date of Dea	th		3. Time of Death
	Physici /Medio		Robert Daniel	ls Fields							March 2	0, 20	004 Year	1:00 AM M
	Examir		4a. Fecility Neme (If not institution		ımber)		4b. City, Tov						unty of Death	
		×	101 Montrose						vill		,		altimo	
	Funeral		5. Social Security Number 203-20-0061	6. Sex 1∭ M 2☐ F	7. Age (In yrs. 77	last birthday) Yrs.	If Under 1 Y Months D	ays	If Under Hours	Min.	8. Date of Birth (Month, Day)	Year)	19269. Birth	plece (State or Foreign intry) insylvania
	Director		Usuel Residence of Decedent			113.					sept zs	, 192	o Pen	insylvania
	land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Man	to	MD Balt	imore		Ca	tonsvi]	l1e						1 ☐ Yes 21 No
	h the	Director	10e. Street and Number	200			10f. Zip Co	de			1	0g. Citizen	of What Cou	intry?
	23a c	alD	101 Montrose A	venue				212	228				USA	
	eep L dee	Funeral	11. Marital Status	12. Was Dec Apped Fo	edent Ever in U	J.S. 13.	Was Decedent	of His	panic Ori	igin? (Sp	ecify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White	
36	within 72 hours after deeth with the Maryland ene. than "natural", or items 23e or 28e-f show he Madical Exhibiter mast be notified at	J.	1 Never Married 2 Marr	ied 1 🖎 Yes tf Yes. Gi	2 No		1□Yes 2🖔				1110011, 010.7	Sa		nite
21215-0036	urai	d by	3 X Widowed 4 □ Divorced	Year or D	Dates: WWI	L								
15-	n 72	Completed	15. Decedent (Specify only highes			16a. Deced	dent's Usual O kind of work d DO NOT use re	ccupat one du	tion <i>uring</i> mos	t of work	ing	16b. Kind	of Business/Ir	ndustry
12	withi ene. than	m C	Elementary/Secondary (0-12)	College (1-4or 5+)		f emplo				i	wo a b a		
0	Hygi Hygi other	S	17. Father's Name (First, Middle,	Last)			Lompic	-		er's Name	(First, Middle, M			manager
an	id be ental ked c	To Be	Wyman Stanley	Fields					Pea	ar1 (hapman			
Maryland	shou nd M mer umat	-	19a, Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (St	reet ar			d Route Number	City or To	wn, State, Zij	o Code)
	alth a 27 is		Catherine S. Ga	aines/dau	ghter	101	Montro	se	Aven	ue C	atonsvil	1e - 1	MD 212	28
J. C.	of Hear		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name of	of					on - City or T	
Ē	Pages ment of I ant: If Ite		1 ☐ Burial 2 ☐ Cremation 4 🖾 Donation 5 ☐ Other (S)		State		atory or ouror	p.200,	1					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exteniner must be notified at once.		21. Signature of Euneral Service Ronal of S	Licensee	iresto	r St Ba	Name and Adate Ana	ddress a to	of Facility By	y gard	655 W.	Balti	more S	Street
			23a. Part1. Enter the disease, or	complications that of	caused the deat									Approximate
	Physician		shock, or heart failure. List Immediate Cause (Final	6.0		1.2	T)	1_	V .	1		_		Interval Between Onset and Death
	/Medical	ļ.	disease or condition resulting in death)	a. Due to	(or as a conseq	uence of):	rros	TG	te		ancer		_	10 years
8	Examiner		Convention line and discon	b										
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):								
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
760,	icate be executed physicien and s the burial-transit		resulting in Geath) Last	Due to	(or as a conseq	uence ot):								
687	e X e	dlcai		d										
9 ×	The law requires that the death certificate the has been signed by the attending phy bage 2 should be detached for use as the	Physiclan/Med	IF FEMALE:	230 H ves ou	tcome of pregna	2004								
Вох	atten for us	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	ointh 2 ∏ Feta nant at time of d	il déath 3□	Ectopic pregna Other (specify					23d.	Date of delive Month	ery Day Year
o	the d	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkn		realii 5	Other (specify	<i>')</i>						
Ω.	res that the de signed by the a be detached f	, Ph	Part II. Other significant condition	ns contributing to d	eath but not res	ulting in the ur	iderlying cause	given	in Part I.		23e. Did tob	acco use o	contribute to t	he cause of death?
Records,	luires n sign	d by									1 □ Ye	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		pably 4 Dunknown
Ö	w require been si should t	lete									24a. Was an	2/	th Were auto	psy findings available
Re	The law ate has page 2 :	Completed								_	autopsy	, '	prior to co death?	mpletion of cause of
Viital		0	25. Was case referred to medical		 -			,	OF Place	of Dooth	1 ☐ Yes 2	No	1 🗆 Yes	2 No
>	/sician: s certific director,	0	examiner?	Hospital:	Inpatient 2	ER/Outpatien	3□ DOA	Other:			(Check only one		Other (Carell	
0	Attending Physician: It death. ector: After this certifics by the funeral director;	L:u	27. Manner of Death	28a. Date		28b. Time of	28c. l	njury a	at	-	8d. Describe ho			y)
ō	uttending I death. ctor: After y the funer	atlo	1 Natural 5 Pending 2 Accident investig	4	in, Day 16ai)	Injury		Work? 1 □ Ye	s 2 □ N	No				
Division	i or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Place	of tnjury - At ho	ome, farm, stre	et, factory, offi	ice		2	8f. Location (Str. City or Town,	eet and Nu	ımber or Rura	al Route Number,
	italo rs aft ral Di led in	Cer									ony or rown,	Olale)		
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier Certifying (Check only one)	g Physician: To the Exeminer: On the b and man	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at the estigation, in m	e time ny opir	, date and nion, deat	d place, a	and due to the can ad at the time, da	use(s) and te and plac	manner as si ce, and due to	tated. the cause(s)
	To the comp	Me	29b. Signature and title of certifier	^			29c. Lic	ense r	number	MAN	yland 29	d. Date sig	ned (Month,	Day, Year)
•			Manus C	Worm	m 1	ND	D	31	15	86		nan	ch 30	, 2004
			30. Name and address of vison v				Print)							
_							reines	>t	Bo	ilbr	nove	MD	212	201
	Sta		31. Date filed (Month, Day, Year)		egistrar's Signa	iture	/							
	Registra	ar	APR 0 6 200	4 Den	1		Darkov!	/						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1

		AM	END ITEM #8 PER INF G834 8/18/04 JHCertificate of Death	Re	g. No.	04 10305
1	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) LOCUSE 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Li	2. Date of Deeth Month	1 20	
) _	Examin	er	4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Li FUTURE CARE 2700 N. CHARLES STREET 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.	IORE	4c. County of N / A	
	Funeral Director		23/ 22 1420 1 M 2X F 83 Yrs. Months Days Hours Min.	SEPT. 10	, 1 923	VIRGINIA
	e Maryland Ba-f show	Director	10a. State 10b. County 10c. City, Town or Location BALTIMORE			10d. Inside City Limits 11 Yes 2 □ No
	affer death with the Marylan or items 23a or 28a-f show miner mant be notified at	erai Dire	10e. Street end Number 2002 BRYANT AVENUE 21217	ט	S. OF	' A.
020	72 hours after death with the Maryland natural; or items 23a or 28a-f show licel Examinar must be notitied at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces 1 1 Yes, specify Cuban, Mexican, Puerto 1 Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes, Give Year or Dates:	ecity Yes of No- Rican, etc.)		American Indian, White, etc. Black
2121	filed within 72 h Hygiene. ther then "natu ent, the Medical	Completed	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) UNKNOWN College (1-4or 5+) UNKNOWN UNKNOWN The state is Name (First, Middle, Last) 16e. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) NURSE 18. Mother's Name	ing	RIVATE	DUTY
	should be fi nd Mental F marked off umatic ever	To Be		MARTHA	ROBINS	ON (DECEASED
Baltimore, Ma	Peges 1 and 2 ient of Health e nt: If item 27 is iry or other trai		SARAH FIELDS (DAUGHTER) 20 0 2 BRYANT AVENUE	Date 20	c. Location - Ci	D. 21217 ty or Town, State
Baltin	pemit. P Depertme importan any injur		21. Signature of Eureral Service Licens, EWIS T. GWYNN LEWIS T. GWYNN LEWIS T. GWYNN 4517 PARK HEIGHT.	FUNERA	L HOME	21215-6393
1	Physician /Medical Examiner		23a. Part 1. Enfer the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition	or respiratory arres	it,	Approximate Interval Between Onset and Death
		Examiner	resulting in death) Due to (or es e consequence of): b. CHRANIC (SCHENIC ENCEP HALE)	OPA747	7	
68760,	e 8 5	edicai Exar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): STAGE REVAL DISEA Due to (or as a consequence of):	SE		
Box 6	eath certificate t attending physic for use as the b	5	d. HYPERTENAIN			
9.	res that the de	F S	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ASRTIC ROST ABSCESS			ibute to the cause of death? □ Probably 4 □ Unknown
of Vital Records,	Ine law requires that the ate has been signed by th page 2 should be detache	Completed by		24a. Wes en performe		24b. Were autopsy findings available prior to completion of cause of death?
ital H			25. Was case referred to medical examiner?	1 ☐ Yes	2.∕ No	1 ☐ Yes 2 ☐ No
Division of V	P Sign	일	1 Yes 2 No	me 5 Residen	injury occurred	
	prtal or Ar burs effer ersl Direc filled in by	Certif	28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, it	City or Town,	State)	or Rural Route Number,
:	vithin 24 hours e To the Funeral C	Medicai	(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred and manner stated.	ed at the time, date	and place, and	d due to the cause(s)
	,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JANS INDA 522 DOLPHIN STREET 31. Date filled (Month Day York)		FARIL	15+ 2004
	b Stat		JAMES TANSINDA 522 DOLPHIN STREET, 31. Date filed (Month, Day, Year) 32, Registrer's Signature,	BALTIN	me me	, aut
er.	Registra	r	31. Date filed (Month, Day, Year) 32. Registrer's Signature			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death AMEND ITEM #1 PER PHY G830 4/14/04 JH 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Year **Physician** KATHRYN H. FRANK -50am Katherine H. Frank march 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Howard Ellicott City Millennium Nursing Home If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 3CXF 84 Director 170-30-0729 27,1919 Penna Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 🏋 ☐ No Directo MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3000 North Ridge Road 21042 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced white Year or Dates: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Lena Kiss Steven Torma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6053 Florey Road, Hanover, MD. 21076 Edward G. Frank/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Marial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Forest Lawn Cemetery 4/02/04 Conemaugh Twp. Pa. of Funeral Service Licenses 22. Name and Address of FacilitWitzke Funeral Homes, Inc. 5555 Twin KNolls Road, Columbia, MD.21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Onset and Death **Physician** THEROSCLEROTIC CARDIOVASCULAR /Medical Immediete Ceuse (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physiclan/Medical Examiner or Attending Physician: Tha lew requires that tha death cartificate be executed usa es tha buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown STEOPOLOSIS Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes iZ ☐ No 11 Yes 2010 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2□ No Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manuar of Death 28b. Time of 28d. Describe how injury occurred Aftar Injury Natural 5 Pending 1 Yes 2 No daath. I Director: A investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) fillad in by To the Hospital or At within 24 hours after of To the Funeral Direct complately filled in by 4 Homicide bacertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 28185 seem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE BALTO MD 21208 1 ASNEEM AKHAN! 7220 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 6 2004 Registrar

		1 - State AMEND ITEM #7	State of Marylan PER 1:H G830 4/06					Reg. No.	2001	1030
Dhysia	25	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
Physici /Medic	*	MARIE	GRIFFIN				APRIL 3			1:05 A M
Examir	ner	4a. Facility Name (If not institution, give s				or Location of D	Death		County of Deatl	
· * * * * * * * * * * * * * * * * * * *	#	PRINCE GEORGES HOS 5. Social Security Number 6. Sex		last hirthday	CHEVE		Hrs. 8. Date of Bir		RINCE GEO	
Funeral Director			M 200 54	Yrs.	Months Days		Min. (Month, Da	y, Year	50 NEW	nplace (State or Foreign untry) YORK
		Usual Residence of Decedent			J -				/	
how		10a. State 10b. County	10c. City	y, Town or Loc	cation					10d. Inside City Limits
e Ma	cto	NEW YORK KING	E	ROOKLYN						1XXYes 2 No
or 20	Director	10e. Street and Number			10f. Zip Code				zen of What Co	untry?
s 23e	rai	925 E. 56 STREET	12 Man Donadant Suns in III	5 12 1	11208		2 (Specific Ven es No		JSA 14. Race - Ame	rione Indian
within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show ta Modical Exertina Ite trufffied at	Funerai	11. Marital Status 1 ☐ Never Married 2XX Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2XX No	.s. 13. V	Yes, specify Cu	ban, Mexican, P	? (Specify Yes or No Puerto Rican, etc.)	•	Black, White	
irs af	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 XX	Specify:			Specify: BL	ACK
2 hou		15. Decedent's Edu			ent's Usual Occu			16b. Ki	nd of Business/l	ndustry
hin 7 9.	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done OO NOT use retir	ed) ed)	working			
or th	Completed	12		NURSE	E'S ASSIST	,			1EDICAL	
be filed within 72 hours after death with the Marylan lat Hygiene. Id other than "natural", or liems 23a or 28e-f show event, tre Medical Exertine mark to trullified at	Be	17. Father's Name (First, Middle, Last) JOHN E. JONES					Name (First, Middle,		Sumame)	
Men Men Marke	ပ္						/IOLA SMITH			
12 should be filed within in and Mental Hygiene. 7 is marked other than "reumatic event, it a Mes		19a. Informant's Name/Relationship (Ty, CLAYTON CRIFFIN	pe, Print)		•		or Rural Route Number			îp Code)
permit. Pages 1 and 2 should be Department of Health and Menta Importent: if item 27 is marked any injury or other treumatic evonce.		20a. Method of Disposition	20b. P	_i _ i	sition (Name of	PLACE, N	RIVERDALE, MI		cation - City or	Town State
nt of h		1XXBurial 2 ☐ Cremation 3XXR	emoval from State	emetery, crem	natory or other pl	3CB)	15/04			
it. Partmer		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundary of rvice License			CEMETERY	ess of Facility	FINK FUNERA		DEN., NJ	
permii Depar Impo any ir once.		KELLY GREGORY	$\mathbf{x}(J) = U \cup J$	4.2			, GLEN BURNI		,	
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		30. Name and address of person who co	impleted cause of death (Item	1 23a) (Type, I				·		
2		TSION BERHANE, MI	3001 t	HOSPITA	L DR		CHEVERLY	, /	MD 2	0785

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year .Physician Wen Gu march 31 10:20 pm 20041 /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice @ Mercy Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) FEB 15, 19 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) Funeral Months Hours 1 □ M 2 🖾 F 213-43-8192 Yrs 39 Director China Usual Residence of Decedent filad withIn 72 hours after death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits works / 1 ☐ Yes 2 ☒ No Director Maryland Ellicott City Howard 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be 2869 Deerfield Drive 21043 Funeral China 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐XNo Specify. Specify: Asian \$ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computers Compute<u>r Programmer</u> 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 end 2 should be f lant of Health end Mantel I nt: If Item 27 le merked of Hanjie Gu Fengzhen Fu 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dong Sheng Zhang/Husband 2869 Deerfield Drive Ellicott City, MD 21043 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If Its any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State **Departmant** 4 ☐ Donation 5 ☐ Other (Specify) 4/2/04 Metro Crematory, Inc. Baltimore, MD 22. Name and Address of Facility
Cremation Society of MD, 21. Signature of Funeral Service Licensee Inc. lwand A. 299 Frederick Road Baltimore, 21228 Edward regorchik MD23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disaase or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner nding physician and usa as the burial-transit or Attending Physician: The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? pege 2 should 24a. Was an autopsy performed? ZX No t ☐ Yes 1 ☐ Yes 2 ☐ No this cartificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Other (Specify) 1 Tes 2 No Medicai Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 □ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital or within 24 hours or To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 40854 2004 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Baltimore beva 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 0 6 2004

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MICHAEL GORMAN Apri 0635AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 37 Vimy Court Middle River Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. April 1 5,1971 5. Social Security Number 9. Birthplece (State or Foreign Country) Virginia 6. Sex 7. Age (In vrs. last birthday) Funeral 1 □ M 2 □ F 32 219-04-3555 Director Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28e-f ehow traumatic event, the Medical Examinar must be notified at MD Baltimore Middle River 1 ☐ Yes 21 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37 Vimy Court 21220 USA iteme 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married "naturel", or 1 ☐ Yes 2 ☐ XNo Specify: Speci**B**lack 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Deperment of Health and Mental Hygient Important: if item 27 ie marked other that eny injury or other traumatic event, that once. Disabled Disabled Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Searcy ပ Charles Gorman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Gorman /father 37 Vimy Court Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State OakLawnCemetery 4/8/04 Baltimore MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Connelly Funeral Homeof Essex 21. Signature of Funeral Service Licenses 300 MAce Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Failure **Physician** Renal years /Medical Due to (or as a consequence of): **Examiner** be-25 ears Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). burial-trar Due to (or as a consequence of): physician Physician/Medical the ettending p as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the pasi 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.0. tha 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No has page 2 certificete **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 1XYes 2 No this After this funeral of 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; Hospital or Attending 5 Pending 1 Natural after death.

Director: Aft d in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after d Funerel Direct letely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILITELLO MD utherville, Mary 6 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar The age 10-52 APR 0 6

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State of Maryland / Department of Health and Mental Hygie	ene 4	U	U

		•	For State Registrar		State of Ma	aryland /		artment of F tificate of		Mental Hy	giene Reg. No.		10310
	Dhuciair		1. Decedent's Name (Firs	t, Middle, La	st)					2. Date of De Month	ath Day	/ Year	3. Time of Death
	Physicia /Medic		Lorna A	Ann Go	ver					March			3:00 P M
	Examin	er	4a. Facility Name (If not in						r Location of Deat	n	4c.	County of Death	
			4772 D:				5 t-45 -t	Ba If Under 1 Year	altimore If Under 24 Hrs.	O Data of Bir	45	Balti	
	Funeral		5. Social Security Number		i⊝M 2∑∏F /.Age	6 (In yrs. last .	οιπησαγ) Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da	y, Year)		place (State or Foreign ntry)
	Director		212-60-4563 Usual Residence of Dece	dent		31				June 1	9, 1	952 Ne	w Mexico
	/land			County		10c. City, To	own or Lo	cation				1	0d. Inside City Limits
	Man,	to	MD	Ba1	timore		Ва	1timore					1 ☐ Yes 2 No
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	th wit	a	4772 Drayto	on Gre	en				21227		Uni	ted Stat	es
	dea	Funeral	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S.	13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No o Rican, etc.))-	14. Race - Americ Black, White,	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Meralla Hygiene. Department of Heelih and Meralla Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, I. a Medical Examinar must be notified at once.	by	1 Never Married 2 3 Widowed 4 D		1 ☐ Yes 2 X N If Yes, Give Year or Dates:	10		1 ☐ Yes 2/ No	Specify:	,			hite
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7	Men Merka Marka	٦	William Jos							R. Tayl			
3	and rand		19a. Informant's Name/R Jim Gover	elationship (Husban				ng Address (Street Drayton					(Code)
ב ס	1 and 1eelth am 27 ther t		20a. Method of Dispositio		<u> </u>					Date		cation - City or To	own State
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	permit. Departr Imports any inju		21. Signature of Funeral	Service Lice	nsee	TUN3	1 2 4	Name and Address					
			23a. Part1. Enter the disc	ease, or com	plications that caused	the death. D	VII.	-				, , ,	Approximate
	Dhuaiaian		Immediate Cause (Final	re. List only	one cause on each lin		1.					Interval Bet Onset and I	
	Physician /Medical		disease or condition resulting in death)	-	a. Tracke		striction						
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (nysician: To the best of miner: On the basis of and manner sta	examination							
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			1 Am	5 &	- MI)		Di	39639		3	-31-00	1
	N		30. Name and address of	person who	completed cause of d	eath (Item 23:	а) (Туре,	Print)		1.5		0.1	
			Ann Zin	NEW Y	M 25	S. G.	6646	St R	sign Als	. M/O	212	10.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 04:30 AM APRIL 03 2004 Troy Lee Good 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMO RE HEALTHGARF N/AACINES If Under 1 Year If Under 24 Hrs. 8. Date of Birth Janneth, Pay, Year) 915 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Min. 89 Months Days Hours 1 ☐XM 2 ☐ F Virginia 228-07-3597 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 ☐ Yes 2X No Baltimore Lansdowne Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 U. S. A. 208 Fourth Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+) 12 General Foreman Refining Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sinai Kibler Oscar Good 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 423 West Maple Rd. Linthicum, MD. Roger Good, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 04-07-04 Elkridge, MD ⁴ 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227 Ella 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final SEPSIS DAYS disease or condition resulting in death) Due to (or as a consequence of): DAYS HYPERCOAGULOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION WITH RAPID VENTRICULAR PATE 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? FAILURE RENAL 24a. Was an autopsy performed? 20 No 1 Yes 1 Yes 2€ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1/ Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1/Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

/Medical **Examiner** certificate be executed and -tran burial-ti Box 68760, attending physician for use as the buria the o that the ል ئ been signed Records, The law requires page 2 should certificate has Vital Attending Physician: this Division of After death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu ö Hospital

Physician

/Medical

Examiner

Director

Completed by Funeral

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Examiner

Physician/Medical

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Certification:

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29b. Signature and title of certifier Asherty

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funeral director,

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the Maryland

s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene at the Alexandra of Sacria and Alexandra Hygiene Andural, or Items 23a or 28a-1 show other traumatic event, Tra Markins Examinating nothing at

Maryland 21215-0036

Baltimore,

Pages 0 = 0

permit. Page Department of Important: If any injury or

Physician

State Registrar

DHMH 17 Rev 1/2001

AYODELE 31. Date filed (1994)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

900 South AVENUE. CATON

Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

16702

29d. Date signed (Month, Day, Year)

APRIL 03, 2004

BALTIMORE MIS

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004

							Cei	rtificate	of	Death			Reg. No.	200	4	10312
	Physicia		1. Decedent's Name (Fi Mae Lilli		-							2. Date of D Month April	Dev)04 Yea		Time of Death 4:30 p.m
)	/Medica Examine		4e Fecility Name (If not			mber)						cation of Dea	th 4c. C	ounty of De		
			Heritage 5. Social Security Numb			7 Ann /In ure	. last birthdey)	If Under 1	Year	Dund If Under		9 Date of Bi		Balti		/C1-4
	Funeral Director		218–16–195 Usuel Residence of Dec	5 1	_м 2√Г F	80	Yrs.		Days	Hours	Min.	8. Date of Bi (Month, D April	10,	1923		y Land
	Maryland	tor	10a. State 10t	o County Baltimo	re		ity, Town or Lo butus	cation								Inside City Limits 1 ☐ Yes 2X No
	h with the 23a or 28s	ai Director	10e. Street and Number 1547 Lester					10f. Zip 0	ode 227				10g. Citize	on of What	Country?	
020	e Sur	by Funerai	11. Maritel Status 1 ☐ Never Married 3 ☒Widowed 4 ☐		12. Was Dec Armed For 1 Tyes, Gi Year or D	2 ZNo ve	'	Was Decede f Yes, specif 1 ☐ Yes 2	y Cube	lispanic Ori en, Mexicar Specify:	n, Puerto I	city Yes or N Rican, etc.)		. Race - Ar Black, Wi pecify:		
21215-0020	d within 72 h piene. r than "netu fre Medica	Completed	15. (Specify of Elementery/Secondar 12	Decedent's Ed nly highest gre y (0-12)	lucation de completed) College ((Give	dent's Usual kind of work DO NOT use emaker	done retired	ation during mos d)	t of workir	ng	16b. Kind	of Busines	ss/Industr	у
70	should be filed and Mental Hygi marked other umatic event, the	To Be C	17. Father's Name (First Cleveland		5							(First, Middle Mae G		,		
	t and 2 sho Health and em 27 ia me		19a. Informant's Name/ Marie Aker									Hall, I		own, State 21128	a, Zip Coa	(o)
Baltimore,	Page lent o nt: if ry or		20a. Method of Dispositi 1 🖾 Burial 2 □ Cro 4 □ Donation 5 □	emation 3 🗆		State	Place of Dispo cemetery, cren adowric	natory or oth	er plac	•	ark (Date 04 - 07-0		tion - City o .kridg		
Balt	permit. Departminents imports any inju		21. Signature of Funera	Service Licen	S00	-						ne, Ind		us, M	íD.	21227
1			23a. Part1. Enter the dis shock, or heart fail	seese, or comp ure. List only	olications that o	caused the dea	th. Do not ente	er the mode	of dyin	g, such as	cardiac o	r respiratory a	rrest,		Inte	proximate erval Between set and Death
	Physician /Medical Examiner	_	Immediate Cause (Final disease or condition resulting in deeth)	Ī	a. CE.	<i>LEBR</i> Due to (OVAS	COLO uence of):	9 K	A	cuj	ENT	_			
68760,	physicia the bur	/Medical Examiner	Sequentially list condition of any, leading to immediate. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	ons, liate	b. A7, c.Cox	Due to (c	or as a consequence or as e consequence	uence of):	E	2×	Di	(SEF)	56		1	
Box (entif ding sa as	anyme		·	d. 2//	4561	ES P	MELL	17	TUS					1	
P.O.	d by the latached	y Physician	Part II. Other significent	conditions co	ontributing to d	eath but not res	sulting in the ur	nderlying cau	se giv	en in Part I.			tobacco us Yes 2□		te to the	cause of deeth?
Vital Records,	law requiras as bean sign 2 should be	Completed by										24a. Was	an autopsy rmed?	24b	availabl	utopsy findings le prior to tion of cause n?
al Re	ian: The law											10		No	1 ☐ Yes	s 20 No
Vit	0 9 6 -	o De	25. Was case referred to examiner? 1 ☐ Yes 2 ☐ No	+	Hospital:	Inpatient 2□	ER/Outpatien	t 3□ DOA	Oth	er: /		(Check only only only only only only only only		Other /Co	noifu)	
ion of	Attending Phy ir death.	- 1	27. Manner of Death	Pending investigation	28a. Dete		28b. Time of Injury		. Injun		2	8d. Describe			ocity)	
Division	Per cer	Serumo.		Could not be determined	28e. Place	of Injury - At h ng, etc. (Special		eet, factory, o	office		2	8f. Location (City or To	Street and N vn, State)	lumber or I	Rural Rou	ite Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completaly filled in by	edical	29a. Certifier 1 (Check only one)	Certifying Phy Medical Exam	iner: On the b	best of my kno asis of exemina ner steted.	wledge, death tion end/or inv	occurred at estigation, in	the tim	ne, date end pinion, deat	d place, ar	nd due to the d at the time,	cause(s) an date and pla	d manner a	as stated.	cause(s)
	within Vithin Comp	Σ	29b. Signature and title of	of certifier	10	Trees	es M.F.	29c. l	icense	7/80	5		29d. Date s	igned (Mor	nth, Day,	Year)
	17		30. Harrie end eddress o	f person who c	ompleted caus	e of death (Iter	n 23a) (Type, F	Print)	2/	ra .	2	Affer	77	/ ~	20	122
	State Registrar	100	31. Date filed ponth, pe	6°2004	COLUMN PROPERTY OF THE PROPERT	egistrar's Signa	ature	Joans	2/	7	- (g)	, , ,				

DHMH 16 Rev 6/95

				State of Marvl	and / Department	of Health and M	Mental Hygier	16 0 0 0 1	
			1 - For State Registrar	,	Certificate		Reg. I	/ 11114	10313
	Dhysisi	an	1. Decedent's Name (First, Middle, L	ast)	Casa		2. Date of Death A Month	Day Year	3. Time of Death
	Physici /Medio		VIRGIN	IA V	GORDON		APRIL 1	2004	5:30 AM
4	Examin	ner	4a. Facility Name (If not institution, g	0	4b. City, To	wn, or Location of Death	'	4c. County of Death	11010=
	Funeral				yrs. last birthday) If Under 1		8. Date of Birth (Month, Day, Yee	9. Birthp	lace (State or Foreign
	Director		216.32.8178	1□M 250 F	88 Yrs. Months	Days Hours Min.	APRIL 20,		SGINIA
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Location		, ,	1	0d. Inside City Limits
	Maryli f sho	ō	11	IMORE T	PARKVILLE				1 ☐ Yes 2 No
	r 28a-	Irec	10e. Street and Number	Tricke	10f. Zip C	ode	10g. (Citizen of What Cour	itry?
	th with	Funeral Director	3027 WILLOW	SHBY ROAD	Z	1234		JSA	
	tems	uner	11. Marital Status	12. Was Decedent Ever i Armed Forces?	in U.S. 13. Was Deceder If Yes, specifi	nt of Hispanic Origin? (Sp Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 □ Yes 2\$	No Specify:		Specify: W.	HITE
215-0036	72 hours after death with the Maryland natural', or tterns 23a or 28a-f show deal Examiner must be notified at	ted	15. Decedent's	Education	16a. Decedent's Usual	Occupation	16b.	Kind of Business/Inc	dustry
218	within 7 ene. than "n	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use	done during most of wor retired)	king ;	1	
121	filed with Hygiene ther thai		17. Father's Name (First, Middle, Lat	.1	DEAMST	18 Mother's Nam	ne (First, Middle, Maid	TURZLER	
Maryland	ould be f Mental It arked of atic ever	To Be		AUGHAN		[=An]	NIE MIL	1:0	
ary.	2 should and Men is marker aumatic	F	19a. Informant's Name/Relationship		19b. Mailing Address (Street and Number or Ru	ral Route Number, Cit	y or Town, State, Zip	Code)
-	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygjene. Importament of Heatih and Mental Hygjene. Importants if item 27 is marked other than "natural", or ttems 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be indifficial at 2008.	-	ROBERT E. BO	2001 / SO1	J 3027 WIL	LOUGHBY_	COAD PAR	KVILLE, M	D 21234
Baltimore	Pages 1 and of He int: If iten		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3	1	b. Place of Disposition (Name cemetery, crematory or oth	of er place)	Date 20c.	Location - City or To	own, State
ţim	permit. Pag Department Important: I any injury o		`4 □Donation 5 □ Other (Spec	city)	FILLSBORD (FIME	TERY APRIL	5,2004 H	ILLSBORO,	VIRGINIA
Bal	permit. Departr Importa any inji		21. Signature of Funeral Service Lic	2011 Laurata	22. Name and	Address of Facility EV	ANS FUNE	RAL CHI	2024
			23a. Part1. Enter the disease, or co	mplications that caused the c	eath. Do not enter the mode	of dying, such as cardiac	or respiratory arrest,	VILLE /VID	Approximat Interval Between
	Physician		shock, or heart failure. List on Immediate Cause (Final disease or condition	y one cause on each line.	Theulan Arc	nont			Onset and Death
	/Medical		resulting in death)	a Due to (or as a con	nsequence of):	- Cora			aug
	Examiner	<u></u>	Sequentially list conditions,	b. — Due to for as a con-					
	ted nsit	nlne	if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	200 to (or 90 3 con	reacquarios (1)				
Ć.	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a con	nsequence of):				· · · · · · · · · · · · · · · · · · ·
8760	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	lical		d					
9	entifica ling ph e as ti	Physiclan/Med	IF FEMALE:	00-14					
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 Live birth 2 1 4 Pregnant at time	Fetal death 3 □Ectopic pred			23d. Date of deliver Month	ry Day Year
o.	that the death certific ed by the attending p detached for use as	nysic	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□ Unknown	or death 3 of other (spec	··· y)			
ď.	rires that signed b d be deta	y Pł	Part II. Other significant conditions	contributing to death but not	t resulting in the underlying cau	se given in Part I.	23e. Did tobacc	o use contribute to th	e cause of death?
ords	w require been sig should b	ted t	WAD SIGNA	s since	alementes	ν	1 ☐ Yes	2 No 3 Prob	ably 4 ⊠Unknown
Records,	fawr ias be	Completed by					24a. Was an autopsy	prior to cor	psy findings available inpletion of cause of
E H	: The licate hat, page						performed 1 ☐ Yes 2 ☐ I	death? No 1 ☐ Yes	20 No
of Vital	Attending Physician: The law r death. ector: After this certificate has by the tuneral director, page 2 s	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ☐ ER/Outpatient 3 ☐ DOA	Othon	ith (Check only one) ome 5 Residence	€ □Other (Free)	
of	> 0 0		27. Manner of Death	28a. Date of Injury (Month, Day Yea		Injury at Work?	28d. Describe how in		()
ion	ath. or: Aft or: Aft	atlo	1 Natural 5 Pending 2 Accident investigat	ion	M	1 ☐ Yes 2 ☐ No			
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		At home, farm, street, factory, oecify)	office	28f. Location (Street City or Town, Sta	and Number or Rura ate)	I Route Number,
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely tilled in by the funeral.	I Ce	29a, Certifier Certifying	Physician: To the best of my	rknowledge, death occurred at	the time, date and place	and due to the cause	(s) and manner as st	ated
	To the Hospital within 24 hours and the Funerat I completely tilled	edical			mination and/or investigation, in				
	To th To th comp	Me	29b. Signature and title of certifier	W	29c.	icense number	29d. (Date signed (Month,	Oay, Year)
	σ .		- William C	· Allenune	lo D	24518	9	ne 2 2	004
	10		30. Name and address of person wh	o complete cause of death	(Item 23a) (Type, Print)	la Arolana D	licel andL	MARANA	01126
	Str	ate	31. Date (propy) on Day, Main in	32. Registrar's S	ignature do la disconsidera de la constanta de	54518 haum B	wa pun	MALE IVIDE	1167
	Regist		HPK U 0 2004	1 may and a second	In papares				

			1 - For State Registrar	State of Maryla		artment <i>rtificate</i>			nd M		Reg.	ne No.20	04	10314
	Physici /Medio		Decedent's Name (First, Middle, La. HERBI			GUSS				2. Date of I		2004	Yeer	3. Time of Death 9:49 A M
	Examir		4a. Fecility Name (If not institution, give			4b. City, To						4c. County		
			12326 PARK HEIGH 5. Social Security Number 6. S		rs. last birthday)			MILL If Under 2		8. Date of E	Righ		ALTIN	
	Funeral Director			X M 2□F	83 Yrs.		Days	Hours	Min.	MAY"	24, Ye	1920	Coun	lace (State or Foreign try) MD
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation							10	Od. Inside City Limits
	Maryl -f eho	ţō	MD BAL	TIMORE		GS MIL	LS							1 ☐ Yes 2 🔀 No
	th the	lrec	10e. Street and Number			10f. Zip C					10g.	Citizen of W	hat Coun	itry?
	s 23e	ral	12326 PARK HEIGH		110			2111						J.S.A.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23e or 28e-f ehow any injury or other traumatic event, the Medical Example must be invitted at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No If Yes, Give		Was Deceder If Yes, specify 1 ☐ Yes 2		spanic Orig i, Mexican, Specify:	n? (Spe Puerto	ecify Yes or I Rican, etc.)	No-		- America c, White, e	
21215-0036	2 hour	ted b	15. Decedent's Ed	Year or Dates:	16a. Dece	dent's Usual (Occupat	tion			16b	. Kind of Bu	siness/Ind	***
215	ithin 7. 16. 18. "a	Completed	(Specify only highest grant Elementary/Secondary (0·12)	Coltege (1-4or 5+)	life.	kind of work DO NOT use	done du retired)	uring most	of worki	ng		11001		
22	filed w Hygier other th	Co	17. Father's Name (First, Middle, Last)		OWNE	.K		18 Mother	's Name	(First, Midd		IARRY		CO.
Maryland	fental fred o	To Be	HARRY		GUSS			ROS		i ii ii si, midd	KLE		7/	
lary	2 should and Men Is marke sumatic	, s	19a. Informant's Name/Relationship (Type, Print)		ng Address (S								
	1 and Health em 27 ther tr		GARY GUSS / SON 20a. Method of Disposition	201	1232 o. Place of Dispo		the same of the same	IGHTS		NUE -	-	NGS M Location - 0		, MD 21117
פֿר	Pages nent of I int: If Its iry or o	1 2	1 Burial 2 Cremation 3 C	Removal from State	cemetery, crei	matory or other	er place			2004				DWN, MD
Baltimore,	permit. Page Department Important: Il any injury o		21. Signatura of uneral Service Live	111		2. Name and								
<u> </u>	8 9 2 8 9) h	MANIMOU	Telliger	/ 8	900 RE	IST	ERSTO	WN R	ROAD -	PIK			MD 21208
		ø 5	23a. Fart1/Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	A	,						arrest,			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Atheroscle Due to (or as a cons		ordiov	us cu	Mar	dis	eare			_	Years
	Examiner		Sequentially list conditions.	b										
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a cons	sequence of):									
	execut n and ial-trar	Exan	that initiated events resulting in death) Last	cDue to (or as a cons	sequence of):									
8760,	ate be executed obysician and the burial-transit	cal		d										
õ	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE:	23c. If yes, outcome of pre-	ananov.									
Вох	d for u	iclan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 F	etal death 3	Ectopic preg						23d. Date Mon		ry Day Year
<u>о</u> .	at the c by the	hysi	9 Unknown	9□ Unknown										-
	res tha	by	Part II. Other significant conditions of	ontributing to death but not i	resulting in the u	nderlying cau	se giver	n in Part I.						e cause of death?
Sor	w require been signature	leted	19 persention											ably 4 Unknown
Re	The lay te has age 2	Completed	- Marispicema						_	per	opsy formed	? pr	ior to com eath?	ssy findings available apletion of cause of
į		Be C	25. Was case referred to medical examiner?					26. Place o	of Death	1 ☐ Yes Check onl		No 1	_Yes :	2 L NO
of <	문 문 등	၉	1 ☐ Yes 2 ☑ No 27. Manner of Death		ER/Outpatier		Other	4 14013		ne 57 Re)
O	Attending Physician: r death. ector: After this certificaby the funeral director.	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year,) 28b. Time o	M 280	. Injury a Work? 1 ☐ Ye	at es 2∐N∈		28d. Describe	o now in	ijury occurre	d	
Division of Vital Records,	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	t home, farm, str ecify)	eet, factory, o	iffice		2	28f. Location City or T	(Street	and Number	r or Aural	Route Number,	
	pital or urs afte eral Dire													
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1/₹ Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my k niner: On the basis of exam and manner stated.	nowledge, deatlination and/or in	h occurred at vestigation, in	my opi	, date and nion, death	place, a occurre	and due to the	e cause e, date a	(s) and man and place, ar	ner as sta nd due to	ited. the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier					number				Date signed		
			Dhoggen	n	· J			584	-					2004
	N		30. Name and address of person who D Roggen 5400	completed cause of death (I	tem 23a) (Type,	Print)	8	Ran	dal	Litowa		MD	211	7.3
	Sta		31. Date filed (Month, Day, Year)	327 Registrar's Sig										
298	Registr	ar	APR 0 6 200	4 . 2.0 .	J. Anna	San Barrell								

	ian	1. Decedent's Name (First, Edna C. Ga.)									2. Date of De	Day	2004	3. Time of De 4:20
/Medi Examir		4a. Facility Name (If not ins			ber)		4b. City,	Town, or	Location	of Death	11 fair Ci		nty of Death	<u>'</u>
Lxamii		MARINER H	FALTH	1 OF B	ELAIR		Be	1 Air				HA	ARFOR	D
Funeral Director		5. Social Security Number 280–26–0573 Usual Residence of Deced		x]M 2 ∑ F	. Age (In yrs. I 98	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Pa June 10	th ly, Year) 1905	9. Birth Cou Ohi	place (Stete or Fi ntry) O
À w			County		10c. City	y, Town or Lo	ocation							10d. Inside City L
F 2	tor	MD H	arford		H	Bel Ai	r							1 ☐ Yes 2X
or 28:)irec	10e. Street and Number					10f. Zip	Code				10g. Citizen	of What Cou	ntry?
238	rai	231 E. Bel	crest						210				JSA	
rai', or itams 23a or 28a-f show Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2[3 ☐ 3 ☐ 3 ☐ 3 ☐ 3 ☐ 3 ☐ 3 ☐ 3 ☐		12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? No		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)	Spe	Race - Ameri Black, White, cify: w	
"natur Bolical	Completed			ication le completed)	4or 5+)	(Give	dent's Usua kind of wor DO NOT us	rk done d	urina mos	t of work	ing	16b. Kind of	Business/Ir	ndustry
I Hygiene. othsr than rent, the M	Son	10		0		1	housev	wife					n home	<u>e</u>
d oths	Be	17. Father's Name (First, M William Gra		ootor							e (First, Middle,			
marked o	၉	19a. Informant's Name/Re				10h Maili	Address	/Can at a			izabeth			
T is mu		Betty March									a <i>l Route Numbe</i> Bel Air		vn, State, Zij 21014	Code)
ent of reauth and mer ht: If Item 27 is marke ry or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crem 1 ☑ Donation 5 ☐ Of	ation 3 🗆 F	Removal from St		Place of Dispo emetery, crei	sition (Nan	ne of	-	_	Date	20c. Locatio	n - City or T	own, State
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vsician		shock, or heart failure Immediate Cause (Final	ase or compose. List only of	lications that cau	used the death ch line.						or respiratory as	rrest,		Approximate Interval Betwee Onset and Dea
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Edna Gallagher

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 2004 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) March **Physician** 1140 K M Harris 31 2004 4c. County of Death /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Genera maryland Hospita If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 1 ☐ M 2 🔀 F 21530 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b County "naturel", or Items 23a or 28a-1 show traumatic event, the Medical Examiner must be nutified at 1 XYes 2 □ No Baltimore MD by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 USA Koval 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: BLACK Specify: 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other then "na any injury or other traumatic even" College (1-4or 5+) AUNDRY Elementary/Secondary (0-12) DRY CLEANER 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ETHEL JOHNSON DAVID WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21132 3725 Springdell Avenue Randallstown MD M. HARRIS VIVIAN 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Randallstown, MD KING PARK ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5/51 BALTIMORE NATIONAL PIKE BALTIMORE MD 21229 Approximate Interval Between Onset and Death Significant midline Shift Immediate Cause (Final Hemorrhage with **Physician** Intracranial disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed inding physicien and use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 4 Monknown 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s 2 3 No certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1. Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending after death.

Director: All
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Tile of certifier

DHMH 17 Rev 1/2001

State Registrar Sunil

Kajan

APR 0 6 2004

31. Date filed (Month, Way, Year)

marylan

HOSDIA

30. Name an address of ear on who completed cause of death (Item 23a) (Type, Print)

70

32 Registrar's Signature

				1 For	State of N	/larylan	•	artment of		d Mental Hy		304	10317
				Registrar 1. Decedent's Name (First, Middle, L	aet)			incate o	Dealit	2. Date of D	Reg. No.		3. Time of Death
		Physici	an		a31)	1	Harris			Month		Year 2004	1108 CM
		/Medic		Andrew 4a. Facility Name (If not institution, g	ive street and number		Idelia	4h City Town	, or Location of D			nty of Deeth	
		Examin	er	C. 14 . L		CKA	(DH WZ	RAI 1	IMOL	25 CIT	4	IA	
		Formul		5. Social Security Number 6.		1	last birthday)	If Under 1 Yea					place (State or Foreign intry)
	Н	Funeral Director		226-34-8586	1 X M 2□F	73	Yrs.	Months Day	rs Hours N	1 7–26	–30		a.
				Usual Residence of Decedent									
- ~ ~		anylan show	_	10a. State 10b. County			ty, Town or Lo						10d. Inside City Limits 1 X Yes 2 □ No
Spaci		Ba-f	cto		IA		Baltim						
B		ith th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen o		intry?
)		ier deeth with the Maryla Iteme 23a or 28a-f ehov ner must be noutfied at	Funeral Director	4136 Norfolk Av		-1 C in 11	10 10	212		/Canada Van as N		Race - Ameri	ican Indian
3		Iteme Iteme	une	11. Marital Status 1 Never Married 2 Married	12. Was Decede Armed Force 1 Tes 2	s?	1.5.	If Yes, specify C	uban, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	14. F	Black, White	
ANDRE	36	Ir, or	by F	3 Widowed 4 Divorced	If Yes, Give Year or Date:			1□Yes 2√XN	lo Specify:		Spe	city: B	lack
4	5-0036	filed within 72 hours after deeth with the Maryland Hygiene. uther then "natural", or iteme 23a or 28e-f ehow uther then "natural" Examinat must be notified at		15. Decedent's	Education	-	16a. Dece	dent's Usuat Occ	cupation		16b. Kind of	Business/li	ndustry
	215	hin 7:	pie	(Specify only highest g Elementary/Secondary (0-12)	College (1-4c	or 5+)	iife.	DO NOT use reti	ne during most of ired)	working			
£	21	filed within I Hygiene. other then '	Completed	10th grade			Mac	hine Ope					l Corp.
A			Be	17. Father's Name (First, Middle, La						Name (First, Middle	•	_{ame)} Johnso	n
2	yla	should be and Mental le marked o aumatic eve	70	Frank	Harr	is	1		Est				
KNOWY	Maryland			19a. Informant's Name/Relationship						<i>Rural Route Numi</i> , Baltimo			
5		s 1 and 3 of Health Item 27 other tr		Gloria Harris 20a. Method of Disposition	Wife	20b. F	Place of Dispo	osition (Name of		, Dalumic Date	20c. Locatio		
X	Baltimore,			1 ☑ Burial 2 ☐ Cremation 3		ite	cemetery, cre	matory or other p	olace)	E 0.4			
	Itin			* 4 ☐Donation 5 ☐ Other (Special Service Licenses)		W	loodlaw	n Cem. 2. Name and Add		-7-04	ltimore	imore,	
	Ba	permit. Departitimport		1	1 Les	1			.H. East		E. Nort		
				23a. Part1. Enter the disease, or co	mplications that caus	ed the dea							Approximate Intervat Between
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V		Examiner		O	Ath	01030	loves	hic Can	LIOVA	scular	dise	ase	70 78943
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	876	× × ×	dicai		d								
	x 68	leath certificat attending phy I for use as the	/Me	IF FEMALE:	23c. If yes, outcor	me of preon	ancy				224	Data of dalis	
	Вох	attene for us	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	ı 2 ☐ Feta	al death 3[Ectopic pregnal				Date of deliv Month	Day Year
	P.O.	that the de ed by the detached	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
		that th	by Ph	Part II. Other significant conditions	contributing to deat	h but not res	sulting in the u	inderlying cause	given in Part I.	23e. Did	tobacco use c	ontribute to	the cause of death?
	rds	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as it	d b	Metastatic	LUNG (ANC	T.	 		_ 1□	Yes 2□No	3 ☐ Pro	bably 4 Saknown
	00	aw requ s been 2 shoulk	Completed							24a. Wa	s an 24	b. Were aut	opsy findings available ompletion of cause of
	Re	sician: The law certificate has b irector, page 2 s	E							per 1 🗆 Yes	formed?	death?	2 No
	ital	ian: rtifica	BeC	25. Was case referred to medical examiner?					26. Place of	Death (Check only			
	_	Physician: this certificated rail director, in	To	1 Yes 2 No	Hospital: 1 Inp		ER/Outpatie	III SLI DOA		ng Home 5 Res	sidence 6 🗆 (Other (Spec	ify)
	n O	ding P	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury		york?	28d. Describe	how injury occ	urred:	
	Sio	tend death for: /	icat	2 Accident investigat 3 Suicide 6 Could no	be as Blace of	Injune - At h	ome farm et	M 1	Yes 2 No	28f Location	(Street and Nu	mher or Ru	ral Route Number,
	Division of Vital Records,	or A	Certification:	4 Homicide determine	building,	etc. (Speci	ify)	ibet, factory, offic	20		own, State)	THOSE OF THE	ar riobto riumbor,
		spite			Physician: To the be								
		To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 Medicel Ex	eminer: On the basi and manner	s of examinations of stated.	ation and/or in	vestigation, in m	y opinion, death o	occurred at the time	, date and plac	e, and due	to the cause(s)
		To the within To the comp	W	29b. Signature and title of certified	111			29c. Lice	ense number	٩	29d. Date sig	ned (Month,	, Day, Year)
				1 Km	July-	~	17)		70045	141	Meril	3,	2004
		6		30. Name and address of person wh	/	of death (Ite	m 23a) (Type	Print)	Hoar	ital		•	*
l		×	240	31. Date filed (Month, Day, Year)	1000	istrar's Sign	ture	y #T I	11034	1111			
		Regist	ate rar	APR 0 6 2004	Maran	1	py	an	V				

JAMES B. HALL 04-02250 RKD

		·	1- State of Maryland / Depa Registrar Cen	rtment of Health and Men		2004 10318
			Decedent's Name (First, Middle, Last)		Date of Death Month Da	3. Time of Death
	Physici /Medio		James B. Hall		RIL 1	. 2004 11:55A. M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
			215 S. Union Ave 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	HAVRE de GRACE If Under 1 Year If Under 24 Hrs. 8, 0		HARFORD 9. Birthplace (State or Foreign
	Funeral Director		216-30-5782 1\(\overline{\text{Ym}}\) 2□ F 73 Yrs.	Months Days Hours Min. Dec	Date of Birth Month, Day, Year, C. 8, 19:	
	D		Usual Residence of Decedent		<u> </u>	_
	ehow	2	10a. State 10b. County 10c. City, Town or Loc			10d. Inside City Limits 1
	28a-f	Director	Maryland Harford Havre do	e Grace	10g Ci	tizen of What Country?
	3a or		215 South Union Avenue	21078		USA
	death ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	/as Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica	Yes or No-	14. Race - American Indian,
9	or He	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	☐ Yes 25 No Specify:	11, 6(6.)	Black, White, etc. Specify:
215-0036	within 72 hours after death with the Maryland ane. than 'naturel', or items 23e or 28e-f ehow the Madical Examiner must be notified at	d by	3 ☐ Widowed 4x Divorced Year or Dates:		100	White
5	in 72	olete	(Specify only highest grade completed) (Give k	ent's Usual Occupation and of work done during most of working O NOT use retired)		Gind of Business/Industry
212	filed with Hygiene. Ather than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 5 General	al Maintenance	Manı	ıfacturer
	S should be filed and Mental Hygid ie marked other aumatic event, II	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fire	st, Middle, Maider	Surname)
yla	should but Ment Ment marked	^L	John Maston Hall	Ruth Melis		
Maryland	12 sh h and h io m reum			Address (Street and Number or Rural Ro Terrace Dr., Dexter		
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Item 27 is marked other than "nature!, or items 23s or 28s-1 show other traumatic event, the Mcdical Examiner must be notified at		20a Method of Disposition 20b. Place of Dispos	ition (Name of Date		ocation - City or Town, State
JOI.	Pages nent of J ant: if its		1 ☐ Burial 2√ Cremation 3 ☐ Removal from State	atory or other place) ervice Corp. 4-6-04		
Baltimore,	그는 근 중		21. Signature of Funeral Service Licepsee 22.	Name and Address of Facility COMAS Funeral Home,	TOWS	son, Maryland
Ö	Depar Depar Impor		Manual Inge	Comas Funeral Home, 317 Cokesbury Road,	Abingdor	n, MD 21009
			23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac or res	spiratory arrest,	Approximate Interval Between
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i in	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
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x 68	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			
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	The law requires that the death certifica ste has been signed by the attending ph bage 2 should be detached for use as th	by Pi	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ord	w require been sig should b	ted	diobetes mellitus		1 ☐ Yes 2	□ No 3 □ Probably 4 ☑ Unknown
Records,	has be ge 2 sh	ple			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
= =		Completed			performed? Yes 2☐ No	death?
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Ch		
of	ਦ ≑ <u>ख</u>	To I	1 Netural 5 Pending (Month, Day Year) 1 Injury 2 Injury 28b. Time of (Month, Day Year) 1 Netural 5 Pending (Month, Day Year) 1 Injury	28c. Injury at 28d.	5 Residence Describe how inju	6XXOther (Specify) SCENE ry occurred
Division	nding Ph tth. :: After th e funeral	Certification:	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		,
Vis	i or Attendi after death. Director: A in by the fu	tifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre-building, etc. (Specify)	et, factory, office 28f. L	Location (Street ar City or Town, State	nd Number or Rural Route Number,
Ö	ital or rs afte ral Dir led in		Building, etc. (Specify)		ony or rown, clare	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1☐ Certifying Physician: To the best of my knowledge, death (Check only one) Medical Examiner: On the basis of examination and/or invegore) and manner stated.	occurred at the time, date and place, and destigation, in my opinion, death occurred at	due to the cause(s t the time, date and) and manner as stated. d place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Da	ite signed (Month, Day, Year)
			How Un-18llen	O.C.M.E.	APR1	IL 2, 2004
	2		30. Name and address of person Ano completed cause of death (Item 23a), (Type, P			
			31. Date filed (Month, Day, Year) 32. Registrar's Signature,	111 Penn Street, Bal	ltimore,	Maryland 21201
	Sta Registr		ADD 0 6 2004	parker		

		•	State Registrar	ate of Maryland	d / Depa			d Mental Hy	Reg. No. 200	* * * * * * * * * * * * * * * * * * * *
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) James Hampton 4a. Fecility Name (If not institution, give street	and number)		4b. City, Town	, or Location of D	2. Date of De Month Marc	Day Yeer	4 11:56 AM
	Funeral Director	eı		d Medical C		Balt tf Under 1 Yes Months Day		Hrs. 8. Date of Bir (Month, Date Oct. 2)	9. Bi ay, Year) 9. Bi 8, 1925 Mar	rthptace (State or Foreign country) Yland
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland ind Mental Hygiene. s marked other then "neturel", or items 23s or 28s-f show umatic event, the Medical Examiner must be notitied at	To Be Completed by Funeral Director	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Vas Decedent Ever in U.s med Forces? Wes, Give ear or Dates: 1943-inpleted) Totlege (1-4or 5+)	16a. Dece (Give life. Main	nie 10f. Zip Code 2106 Was Decedent of Yes, specify Ci 1 Yes 2 Xi dent's Usual Occ kind of work doi DO NOT use ret	of Hispanic Origin or buban, Mexican, Pictor Specify: cupation most of fired) Supervi: 18. Mother's Ruth	sor Name (First, Middle Wilkerson	Specify: No 16b. Kind of Busines Nevermar (On, Maiden Sumame)	nerican Indian, ite, etc. White s/Industry Corporation
Baltimore, Mar	permit. Pages 1 and 2 sho Department of Health and Importent: If Item 27 is m any injury or other traum <u>9068</u> .		19a. Informant's Name/Relationship (Type, PMrs. LaVern Hampton - 20a. Method of Disposition 1 Buriat 2 Cremation 3 Remove 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	- wife	105 Collace of Disposemetery, creren Have	ondon Average of Matery or other pen Mem.	venue, G	Date r 5,2004	e, City or Town, State, e, Maryland 20c. Location - City o Glen Burni Funeral Ho n Burnie, M	1 21061 or Town, State e, MD
760,	Physician /Medical Examiner per property per property per per per per per per per per per per	ical Examiner	23a. Peril. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	use on each line.	stem uence of):		orrhage			Approximate Interval Between Onset and Death
P.O. Box 68	t the death certifica by the attending pt lached for use as t	by Physician/Med	in the past 12 months?	yes, outcome of pregna □Live birth 2 □ Fetal □Pregnant at time of do □Unknown	death 3	Ectopic pregna Other (specify,			23d. Date of d Month	Day Year
Records, F	The law requires tha sate has been signed page 2 should be del	Completed by P	Part II. Other significant conditions contribution atrial fibrillation hypertension		ulting in the u	nderlying cau <i>s</i> e	given in Part I.	1 🗆 24a. Was	s an 24b. Were a prior to death?	Probably 4 Onknown autopsy findings available completion of cause of
Division of Vital	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate completely filled in by the funeral director, page.	Certification: To Be Co	1 Natural 5 Pending 2 Accident investigation	Ba. Date of Injury (Month, Day Year) Be. Place of tnjury - At he building, etc. (Specific		f 28c. lr	Other: 4 Nursin	28d. Describe	2 No 1 Ye one) idence 6 Other (Sp how injury occurred (Street and Number or I wn, State)	ecify)
	To the Hospitel of within 24 hours at To the Funeral D completely filled it	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physicial 2 Medical Examiner:			vestigation, in m	ense number	occurred at the time,	, date and place, and du	nth, Day, Year)
	di	ate	30. Name and address of person who comple 21 Southe Greene St 31. Date filed (Month, Day, Year)	heet Balti 32. Registrar's Signa	more,	Print)	16551 and 21	201 Nic	March holas S	Zenlip
	Regist		APR 6 2004	Stephen	9	lon V.	/			

			For State Registrar		Marylan		artmen ertificat			Mental Hy	Reg. No.	004	1(0320
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	Examir		4a. Facility Name (If not institution, give. SAINT AGNES +	bartho	are		B	ILTI	Location of Dea		N,	ty of Death		
v.	Funeral Director			x' 7. A M 2□F	67	last birthday Yrs.	Months		If Under 24 Hr Hours Mir	. (Month, D	rth ay, Year) 5, 1936		place (State ntry) 'yland	or Foreign
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	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28e-f show other traumatic avent, the Madical Exertifier must be notilised a	Funeral Director	10e. Street and Number 1010 Downton Rd.		AI		10f, Zip	Code			10g. Citizen o			- A
	after death w or Items 23a	uneral	11. Marital Status	12. Was Deceder Armed Forces	s?				ispanic Origin? (In, Mexican, Pue	Specify Yes or Norto Rican, etc.)		ace - Americack, White,		
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Maryland 21215-0036	within 72 ene. than "nat	Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		r 5+)	(Giv life.		rk done d se retired	during most of wi f)	orking .rm Insta	16b. Kind of		ecuri	ty
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Maryl	12 should h and Me 7 Is mark traumatic	2	19a. Informant's Name/Relationship (7) Frederick W. Helmo	rpe, Print)					and Number or F	Tural Route Numb	-	n, State, Zip	Code)	7
	ges 1 and 2 t of Health If item 27 I		20a. Method of Disposition 1XXI urial 2 □ Cremation 3 □		e c	lace of Disp emetery, cri	oosition (Nar ematory or o	ne of ther plac	(e)	Date	20c. Location	- City or To		
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot		*4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens		Mea					04-06-0		idge,	MD	
ï			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that causene cause on each	ed the death		1328 8	Sulph	nur Spri	ng Rd.	Arbutus	s, MD.	212 Approxima Interval Be	ate etween
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PNIG	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	as a consequ	wence of):	91F	2 112			w =10==	- 5	IX W.	onths
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MPRT Box 687	m		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregna	ncy		4 - 4			234 [ate of delive		011112
FLMPR P.O. Box 6		by Physiclan/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	at time of de		□Ectopic pr □ Other (sp					lonth	Day	Year
T o		d by Pt	Part II. Other significant conditions co	ntributing to death	but not resu	ulting in the	underlying c	ause give	en in Part I.	11	tobacco use co Yes 2 □ No			
€. Record	The law requires ate has been sign page 2 should be	Completed								24a. Was auto perfe	psy ormed?	death?	npletion of	s available cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	-lospital:				Othe		1 ☐ Yes	one)		2□ No	
RIC On of	eri feri	lon: To	27. Manner of Death 1 Manual 5 Pending	28a. Date of In (Month, D	tient 2 njury Day Year)	28b. Time Injury		8c. Injury Work	4 □ Nursing / at ⟨? Yes 2 □ No	Home 5 Res	how injury occu)	
EDERIC	or Attentiter deat	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At ho etc. (Specify						Street and Nun wn, State)	ber or Aura	l Route Nui	mber,
B X	To the Hospitel within 24 hours a To the Funerel Completel, filled	edical Co	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the besiner: On the basis and manner:	of examinal	wledge, dea tion and/or i	ath occurred investigation	at the tim , in my op	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and r	nanner as st	ated. the cause	(s)
	To the Hos within 24 To the Fun completel	Me	29b. Signature and title of certifier	00m0	renomo	2 (000		: License	number	Doorlan	29d. Date sign	ed (Month,	Day, Year)	~}/
	10		30. Name and address of person who c	ompleted cause of				01/2	FLORALE	Side.	10/412	- 47	217	ur thesis
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 10321 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2004 April 3, **Physician** Year Cecilia Hoff 12:00P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Future Care Nursing Home Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
April 25, Birthplece (State or Foreign Country) Funeral 1□M 2▼F Months 91 Mary Land 1912 Director 220-12-7616 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examination intest or motified at N/A Maryland Baltimore 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 South Athol Ave. 21230 U. S. A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. illed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within thment of Health and Mental Hygiene.
 rtant: If itam 27 ie marked other than Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Good Will 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Hoff Emma Helbing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frank Hoff, brother 5625 Ashbourne Rd. Baltimore, MD. 21227 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State injury or permit. Page Department of Important: If any injury or New Cathedral Cemetery 04-07-04 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licenses once. - S 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** THEROSCLEROTIC CARDIOVASCULAL DISEASE disease or condition 1 EAR resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely the 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) APRIL 5th, 2004 asanthatuma 112510 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 105, MVASANTHAKUMAL 516. N. ROLLING ROAD, # 14021228 31. Date filed (Month, Day, Year) APR 0 6 2004 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Please 1	Type or Print in Blac				
For State Registrar	State of Maryland /	Department of I	lealth and Mental Hy <i>Death</i>	giene 2004	10322
1. Decedent's Name (First, Middle, Lass	Parie Hai	llam	2. Date of De Month	Pax 7 Year	3. Time of Death
4a. Pacility Name (If not institution, give	e of Bultim	ore Balts	r Location of Death	4c. County of Deat	-
5. Social Security Number 6. Se 337-52-9640 15 Usual Residence of Decedent	7. Age (In yrs. last b	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Date of Bi Hours Min. (Month, Date of Bi		holace (State or Foreign untry) CNIGAN
10a. State 10b. County Maryland Baltim	ore Co. Coc	keysurlle			10d. Inside City Limits 1 ☐ Yes 22 No
10535 York Ro	oad #207	10f. Zip Code	030	10g. Citizen of What Co	untry?
11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hif Yes, specify Cub	dispanic Origin? (Specify Yes or No an, Mexican, Puerto Rican, etc.) Specify:	14. Race - Ame Black, White Specify:	
15. Decedent's Ed (Specify only highest grad	ucation 16 de completed)	a. Decedent's Usual Occup (Give kind of work done	during most of working	16b. Kind of Business/	Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Home	Maker	Own t	tome
17. Father's Name (First, Middle, Last) UNKNOWN			18. Mother's Name (First, Middle	, Maiden Sumame)	
19a. Informant's Name/Relationship (T		in i of -	and Number or Rural Route Numb Manium Rd.	er, City or Town, State, 2	mail -> 1000
20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State cemet	of Disposition (Name of ery, crematory or other pla Funeral Chape	BelA1 4-1-04	20c. Location - City or Forest,	1/ 1/ 1
21. Signature of Funeral Service Licens	F. gan, so	Peacety 1 2325		s fineral	+ (remakon () D. 21093
23a. Part1. Enter the disease, or composhock, or heart failure. List only of	lications that caused the death. Do one sause on each line.	not enter the mode of dyin	ng, such as cardiac or respiratory a	rrest,	Approximate Interval Between Quest and Death
Immediate Cause (Final disease or condition resulting in death)	a. Oue to (or as a consequence	brain 1	ujang		Sacrif
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as a consequence	,	6.		
resulting in death) Last	Due to (or as a consequence	e of):	TETCATION APPROVED PO		
			FA	Te L L	

Physician /Medical Examiner

attending physician and for use as the burial-transit

ed by the a detached f

certificate has been signed rector, page 2 should be del

nerel Director: After this certific tilled in by the funeral director,

within 24 hours after death.

To the Funerel Director: A
completely filled in by the fu

The law requires that the death certificate be executed

To the Hospital or Attending Physicien:

Division of Vital Records, P.O. Box 68760,

Department of Health a importent: If item 27 is any injury or other tra

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

IF FEMALE:

Physician /Medical

Examiner

Director

Completed by Funeral

To Be

Examiner

Physician/Medical

by

Completed

Be

Certification:

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ent: If item 27 is marked other than "naturel", or items 23e or 28e-f show

item 27 is marked other than "naturel", or items 23e or 28a-f show other traumatic event, the Medical Examinar must be notified at

23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death

4 Pregnant at time of death

3 ☐Ectopic pregnancy 5 Other (specify)

MCAE EXAMINER 10 23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

G C intersation / House

24a. Was an autopsy performed? 1 ☐ Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

12 Yes 2 No 27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 - Homicide

Hospital: 1 popatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Yarth 25, 2004 /7:00 PM

28c. Injury at Work? 1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred in Courch arest at bottom of Phips of

29a. Certifier

SAFAR

5 Pending

investigation

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) City or Town, State)

City or Town, State)

City or Town, State)

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

Hospital of Baltimore

RES - 000

26. Place of Death (Check only one)

March 27, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BASHAR 31. Date filed (Month, Day, Year) APR 0 6 2004

Siqui 32. Registrar's Signature

MD

State Registrar

3

		State of Maryland / Department of Health and	Mental Hyg	giene	10000	
	1 - State Registrar Certificate of Death			Reg. No. 2004 10323		
Physici	1. Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death	
/Medic		Michael David Harryman 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	MARCH	28 2004 4c. County of Deat		
Examin	er	4a. Facility Name (If not institution, give street and number) Circle #119 Concord House / 10850GreenMountainColumbia	ın	Howard	n	
Funeral		5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birtl	9 Bird	hplace (State or Foreign	
Director		217-62-9576 149 Yrs. Months Days Hours Min	. (Month, Day Dec. 23		untry)	
B .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
larylan ehow	'n	Tod. State Tob. County			1 Tyes 2 No	
the M 28a-f	Director	MD. Howard Columbia 10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	uuntry?	
th with	ā	10850 Green Mountain Circle#119 21044		USA		
ter death Itams 23	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (5	Specify Yes or No-	14. Race - Ame		
or Ita		Armed Forces? 1972 X Never Married 2 Married Ma	то нісал, өтс.)	Black, Whit		
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nati	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of wo life. DO NOT use retired)	orking	16b. Kind of Business	Industry	
withir ene. then		Elementary/Secondary (0-12) College (1-4or 5+)		health ca	re	
Hygi Hygi Sther ent, I	a)		me (First, Middle,		11.0	
lid be lental rked	To B	Howard R. Harryman Ardeth	J. Her	ald		
2 should and he ls mail		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R	ural Route Numbe	r, City or Town, State, 2	Zip Code) 21113	
1 and 2 should be filed within the and 2 should be filed within the answer of the answer of the the answer of the them the treumatic event, it a file		Aracen b. dersymother 2408 Chestnut Ter:	race Co	urt,Odent	on, Md.	
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		'4 Donation 5 Other (Specify) Balto/ Wash. Crematory				
permit. Departi Import any inj once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Home, Inc.				
Name of Street, or		23a. Part 1. Enter the disease, or coup cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. 15555 Twin Knolls Road, Columbia, Md. 21045 Approximate Interval Between				
Dhustalan		shock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition Wetcstatic head a Neck Concer State of the Concer State of th				
Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):				
Examiner		Sequentially list conditions, b.			U	
Pit sq	iner	if any, leading to immediate Due to (or as a consequence of):				
cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):				
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phy cate	edical	d.				
anding use a	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	ivery	
The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 Ves 2 No 1 Unknown 1 Close birth 2 Fetel death 3 Ectopic pregnancy 1 Other (specify)		Month	Day Year	
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ries th	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			obably 4 Unknown	
w require	etec					
has l	Completed	<u> </u>	24a. Was autop	sy prior to	topsy findings available completion of cause of	
in: Th	e Co	25. Was case referred to medical 26. Place of De	1 ☐ Yes ath (Check only or	2No 1 ☐ Yes	2 No	
ding Physicien: The lav h. After this certificate has funeral director, page 2	O B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing I	V	ence 6 Other (Spe	cify)	
g Ph ter th	T:U	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ow injury occurred	,,	
endin path. or: Af	atic	2 Accident investigation M 1 Yes 2 No				
or Att fter de drect n by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,	
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To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director,	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Check only one) Additional Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
Fo the within Fo the	Me	29b. Signature and tine of certifier 29c. License number		29d. Date signed (Month	n, Day, Year)	
1		M3 (4139	{	warch a	9504	
30		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			,	
V		Clement B. Knight, M.D. 11065 Little Patuxar	nt Pkwy	Columbia	a,Md.21044	
Sta Regista		31. Date filed (Month, Day, Year) APR 0 6 2004 Specific Signature	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND ITEM #23b&c PER PHY G830 4/06 Pertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer **Physician** 12.40 26 orch 2004 /Medical 4c. County - BALT 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Deeth **Examiner** MAR IMON 1 TMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1**₹**1 M 2□ F Hours 217-26-5282 86 Yrs Director 1,1917 June Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23a 407 Allview Court 21228 death v U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 文 Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify þ 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) other than Real Estate Title Research Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H is marked of Be William Oliver Haves, Sr. Mary Alice Putnam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Itam 27 is any injury or other trau Maureen H. Kendall (Daughter) 6216 Fair Oaks Ave Baltimore, Maryland 21214 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 3-30-2004 Baltimore, Maryland 21. Signature of Juneral Service Lie Name and Address of Facility tzke Funeral Home of Catonsville, Inc. 30 Edmondson Avenue Catonsville, Maryland 21228 r Ka 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DAYS /Medical Due to (or as a consequence of): Examiner NEPHROS LEPOSIS MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit YEARS HYPERTENSION Box 68760, by Physiclan/Medical IE FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 BNo Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a Ö 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? 1. Yes 2 No 3 Probably 4 Unknown Completed peeu 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No page 2 s certificate To the Hospital or Attending Physician: Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 K Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No this ieral Director: After th filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 19 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 | Homicide 1 C-critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

12:40

31. Date filed (Month, Day, Year) State APR 0 6 2004 Registrar

29b. Signature and title of certifier

mesting

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERNESTINE A. WRIGHT, M.D. 2. Registrar's Signature

2300 DULANEY VALLEY ROAD

29c. License number

21093

MD

TIMONIUM

			For State Registrar			•		of He	alth a		ental Hygi	ene a. No. 2 (004	10325
	Physici		1. Decedent's Name (First, Middle THE RESA		2.5						2. Date of Death Month APIZIL		Year 2004	3. Time of Death 8.05 A M
	/Medic Examin		4a. Facility Name (If not institution Northwest Hos	-	umber)		4b. City, T Ra	own, or L			V	4c. Coun	ty of Death	e
	uneral irector		5. Social Security Number 214–64–2652	6. Sex 1 □ M 2 □ X F	7. Age (In yr. 48	s. last birthday) Yrs.	If Under		If Under 2 Hours	Min.	8. Date of Birth (Month, Day, 10-21-	Year) 55	9. Birthp Coun Md .	lace (State or Foreign try)
death with the Maryland	r 28a-f show	or	Usual Residence of Decedent 10a. State 10b. County Md. Balt	imore	10c. (City, Town or Lo	cation	N.777					1	0d. Inside City Limits 1X Yes 2 □ No
th the A	or 28a-	Director	10e. Street and Number	INOLE		Nanae	10f. Zip				10	g. Citizen o	f What Coun	try?
ath wi	23a	ral	9828 Tollwort					1133					SA	
9	other than "natural", or Items 23a or vent, the Medical Examinar must be	by Funeral	11. Marital Status 1 ▼Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ned 1 ☐ Yes	2 No live		Was Decede f Yes, speci 1 ☐ Yes 2		Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		ace - Americ ack, White,	
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arytand should be file	arked of	To Be	17. Father's Name (First, Middle, Julian	E.		Jones,	Sr.	1.		arga:	(First, Middle, M		kins	
N W	7 Is ma trauma		19a. Informant's Name/Relations Julia Jones	ship <i>(Type, Print)</i> Brothe	æ						I Route Number, oodstock		n, State, Zip 2116	
a, - 4			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	20b.	. Place of Dispo cemetery, crer	sition (Nam natory or oth	e of her place)		D	ate 2	0c. Location	- City or To	wn, State
Saltimore,	Important: If ite any injury or or once.		*4 □Donation 5 □ Other (5		,		. Name and	Address	of Facility	200	Bal	timore	e, Md.	n, Md. 21202
n 82	2 5 5 9		23a. Part1. Enter the disease, o shock, or heart failure. List	- A That is a that	caused the de		March er the mode				1101 E		th Ave	Approximate
	/sician		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)			TIC I	-					.,		Interval Between Onset and Death MONTHS
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/60,	nysician and he burial-transit	cal Exa	that initiated events resulting in death) Last	c. Due to	o (or as a conse	equence of):								
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O. BOX 68 the death certifica	by the attending parached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐No 9 ☐ Unknown	1 Live	utcome of preg birth 2 ☐ Fe gnant at time of nown	etal death 3	Ectopic pre Other (spe						ate of delive fonth	ry Day Year
J ig	pe de	by	Part II. Other significant conditi	ons contributing to	death but not re	esulting in the u	nderlying ca	use given	in Part I.			acco use con		e cause of death?
VITAL RECORDS, P.O sician: The law requires that the	cate has been sig page 2 should b	Completed									24a. Was an autopsy perform	ed?	prior to con death?	osy findings available appletion of cause of
	certificate rector, pag	BeC	25. Was case referred to medica examiner?							of Death	(Check only one		1 1 1 1 1 1 1 1	2 NO
o t	his	P	1 ☐ Yes 2 No 27. Manner of Death	28a. Dat	e of Injury	ER/Outpatier			4 11401		ne 5 Resider)
SION ending	or: After	atlon	1 Accident 5 ☐ Pending investi	ng (Mo igation	nth, Day Year)	Injury	М	lc. Injury a Work? 1 Ye	s 2 🗆 N			,,		
DIVISION To the Hospital or Attending	al Director: After ted in by the funera	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 289. Pia	ce of Injury - At ding, etc. (Spec	home, farm, str cify)	eet, factory,	office		2	28f. Location (Stre City or Town,		nber or Rurai	Route Number,
he Hospl	To the Funeral D completely filled in	Medical	29a. Certifier (Check only one)	ng Physician: To the Examiner: On the and ma	ne best of my k basis of exami inner stated.	nowledge, death nation and/or in	occurred a vestigation,	t the time, in my opin	date and ion, deat	d place, a h occurre	and due to the cau ad at the time, dat	use(s) and m e and place	nanner as sta , and due to	ated. the cause(s)
Tota	To the complete	Σ	29b. Signature and title of certified Quart	penaper	MO		29c.	D54	1-28	8	29	d. Date sign	ed (Month, L	2004
0	2		30. Name and address of person	who completed ca		em 23a) (Type,	Print)	VEST	HOSP	MAL	CENTER	2		
	Sta Registi		31. Date filed (Month, Day, Year,	32.	Registrar's Sig	nature	Spa	eks'			ed at the time, dat			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William F. Jones State of Maryland / Department of Health and Mental Hygiene 04-02070 RJ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month William F. Jones March 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 727 Druid Park Lake Drive, 11D Baltimore 8. Date of Birth (Month, Day, Year)
June 22, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Unk 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 69 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County f ahow r 28a-f ahow MD Baltimore Directo 10e. Street and Number 10f. Zio Code r than "natural", or Items 23e or the Medical Examiner must be 727 Druid Park Lake Drive 21218 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 7 is marked other than traumetic event, the Mi Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be end Mental 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tra O.C.M.E.

3. Time of Death

0617

Birthplace (State or Foreign Country)

10d. Inside City Limits

1X Yes 2 □ No

unk

unk

Approximate Interval Between Onset and Death

Day

2004

4c. County of Death

10g. Citizen of What Country?

Specify:

21201

20c. Location - City or Town, State

23d. Date of delivery

29d. Date signed (Month, Day, Year) March 25, 2004

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Year

Month

111 Penn Street Baltimore, MD

State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

20b. Place of Disposition (Name of cemetery, crematory or other place)

USA

16b. Kind of Business/Industry

14. Race - American Indian, Black, White, etc.

black.

Physician /Medical Examiner

permit. Page Department of Importent: if any injury or once.

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

'4 □Donation 5 📉 Other (Specify) in state

21. Signature of Fig., rat Survice Licensee

neur

Examine signed by the attending physician and I be detached for use as the burial-transit Physician/Medical Completed by certificate has bruector, page 2 s director Medical Certification: To Be

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital or Attending Physician:

Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 1 ☐ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE Hospital: 1XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Director

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

State Registrar

filled in by the funeral

After

after death.

within 24 hours after of To the Funerel Direct completely filled in by

To the Hospitel

31. Date filed (Month, Day, Year) MPR 0 6 2004

30. Name and address of person who complete

29b. Signature and title of

S.K.

32 Registrar's Signature

cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 DOCKE

29c. License number

Security Name of the controlling give stones and number) 30.5 E. Joppe Road, Apr. 1010 Towson Rattimore Security Number Securi			State of Marylar 1- State Unpend Item #23a&27 per me G830			•		10327
March Department Departme	/Me	dical	LHZRYL A TORS 4a. Fecility Name (If not institution, give street and number)			March	4c. County of Death	3:10 P M
104 September 105 County 106 College			277-10-1787 10W SQE 20			n (Month, Day, Y		
The standard Michael Standard Deposition of Proper of the Standard	th the Maryland or 28a-f ahow	Director	10a. State 10b. County 10c. Ci		200	10g		10d. Inside City Limits 1 ☐ Yes 2 No ntry?
The start's Name (Pist, Modile, Last) 17. Fester's Name (Pist, Modile, Last) 18. Informat's Name (Pist, Modile, Last) 19. Maling Address (Street and Number of Rout Route Manday City or Town, Start, 20 Cook) 2 Name of Start St	ours after death wirel, or Itama 23a	by Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces? 1 Yes, Give 13 Widowed 4 Divorced 14. Was Decedent Ever in U Armed Forces? 1 Yes, Give Year or Dates:	J.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- and Rican, etc.)	Black, White,	
Second Control Seco	n p b a			(Give	kind of work done during most of w DO NOT use retired)	orking	uznelo	•
200 Machod of Deposition 200 Place of Disposition Name of Disposition 200 Place of Dispos	and year and Men		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	Viol	ET KA	NU	Code) ZILS3
Physician Physician (Indicated Season, or complete allows the death of	Baltimore, Ma permit. Pages 1 and 2: Department of Health at Important: if Item 27 is any injury or other treu		20a. Method of Disposition 1	11.H72010	MARYLAND			
Due to (or as a consequence of): Due to (or as a consequence of):	/Medic	al	Immediate Cause (Final disease or condition resulting in death) Atherosclerot: Due to (or as a consequence)	ic Cardi	er the mode of dying, such as cardi	ac or respiratory arrest		Approximate Interval Between
FFEMALE 23b. Was decedent pregnant in the past 12 months?	te be executed ysician and he burial-transit	cai	resulting in death) Last C. Due to (or as a consequence)					
25. Was case referred to medical examiner? 1 2	the death certifica y the attending ph ached for use as th	nysiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Wes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnat 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	ıl death 3 □				•
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The state of Death 1 Manner of		O				autopsy performed 1 Yes 2	d? prior to con	mpletion of cause of
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Sign fure and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30 (Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201	ing Phy Witer this uneral d	To B	examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐	28b. Time of Injury	ot 3 DOA Other: 4 Nursing 28c. Injury at Work? M 1 Yes 2 No	Home 5 Residence 28d. Describe how 28l. Location (Street	injury occurred	
29b. Sign rure and title of cuttier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201	Hoapite 14 hours Funeral tely filled			wledge, death	n occurred at the time, date and place vestigation, in my opinion, death occ	e, and due to the caus curred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
MARICIA ATONICA - POLAKOWIII Penn Street, Baltimore, Maryland 21201	To th To th comp	Me	29b. Sign rure and title of contrier	Lav	O.C.M.	ľ	Date signed (Month, a	Day, Year)
Tank and the second sec			KATRICIA ATONICA-POLLA	Kaw 11		Baltimore,	Maryland 2	1201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Malinda Helen Johnson 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) N/A St. Agnes Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours 1 □ M 2x□xF 91 Yrs. Jan 8, Kentucky 278-12-8735 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location N/A Baltimore 1X Yes 2 □ No Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3650 Keswick Road 21211 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 0sborne Amy Hannah 0ra 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Glen Burnie, Maryland 21060 17 Davis Court Kenneth Johnson Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5xxOther (Specify) Entombment Dulaney Valley Memorial 4/6/04 Cockeysville, Maryland 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road, Baltimore, Maryland 21. Signature of Funeral Service Licens 23a. Part1. Enfor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Hospital: 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М

/Medical Examiner anding physicien and use as the burial-transit The law requires that the death certificate be executed P.O. Box 68760 signed by the al Records. cate has been sig , page 2 should b this certificate Division of Vital After

Physician

/Medical

Examiner

Funeral

Director

Examiner must be notified at

Iteme 23e

s 1 and 2 should be tiled within 72 hours after death v if Health and Mental Hyglene. item 27 is marked other than "natural", or Iteme 23

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic av-

Physician

ntal Hyglene. ed other than "nature event, tre Medical E

Maryland 21215-0036

Baltimore,

Director

Completed by Funeral

Be

with the Maryland or 28a-f ehow

> Physician/Medical Examiner þ Completed Be

the Hospital or Attending Physician: Certification: within 24 hours after death. To the Funeral Director: A 2 ☐ Accident filled in by the 3 Suicide 4 Homicide 29a. Certifier Medical (Check only one)

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 P certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

tener-Larsen us:

ausenit who completed cause of death (Item 23a) (Type, Print)

D35537

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

5411 Old Frederick Rd, F18, Baltimor, MD 21227

State Registrar 31. Date filed (Month, Da

32. Regisfrar's Signature Beper

		-	For State Registrar	State of Maryland	d / Depa <i>Cer</i>	irtment of He tificate of L	ealth and M Death	ental Hyg	iene 19. No. 200	+ 10329
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Jon				2. Date of Deat	Day 1 - Yea	3. Time of Death
8	/Medic Examin	er	4a. Facility Name (If not institution, given 1917 W. SARATOGA 5. Social Security Number 6. Sex		ast birthday)	4b. City, Town, or BALTIN If Under 1 Year	IORE If Under 24 Hrs.	8. Date of Birth	4c. County of De	lirthplace (State or Foreign
	Funeral Director			M <u>≱C</u> XF 9.	5 Yrs.	Months Days	Hours Min.	(Month, Day, 7-9-190		OUTH CAROLINA
	anyland show	o.	10a. State 10b. County MD • N/A		Town or Lo					10d. Inside City Limits 1∏Yes 2 ☐ No
	or 28a-	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
φ.	tiled within 72 hours atter death with the Maryland Hyglene. ther than "naturel", or Items 23a or 28a-f show ther than "naturel", or Items 23a or 28a-f show int, the Medical Examination at	Funeral	1 Never Married 2 Married	ST • 2. Was Decedent Ever in U.S Armed Forces? 1		21223 Was Decedent of Hi f Yes, specify Cubai 1 □ Yes 2☑ No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi	
21215-0036	should be filed within 72 hours nd Mental Hygiene. marked other than "naturel", imatic event, the Medical Exa	Completed by	3 Widowed 4 □ Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates:	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of work	ing	16b. Kind of Busines	
d 212	filed with Hygiene other the	Com	-7 - 17. Father's Name (First, Middle, Last)	-0-	JOH	SEKEEPING	18. Mother's Name	(First, Middle, I	DOMESTI Waiden Sumame)	C
Maryland	ed ita	To Be	SAUL HUDGENS					JACKSON		To Code)
	2 6 5 2		JAMES JONES (SON)	ne, Print)					City or Town, State MILLS, N	ARYLAND 21117
altimore,	Pages 1 and 3 nent of Health int: if Item 27 iry or other tr		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Cother (Specify)	emoval from State		sition (Name of matory or other place VALLEY MEN		2004	20c. Location - City	
Baltin	permit. Pages Department of I Important: If It any injury or o		_ //	SONATHAN D. H	IBNER ²²	2. Name and Addres	s of Facility PHI	LLIPS FU	JNERAL HŌM	
	Physician /Medical Examiner	ner	23a. Part Enter the disease, or complice shoot, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of the consequence)	Jence of):		g, such as cardiac (or respiratory arr	est,	Approximate Interval Between Onset and Death (CAS (Coul))
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	n/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	Due to (or a a 1 nsequence of nsequence of pregnation of the limit of	ncy	3 ieu			23d. Date of d	
.O.	that the death led by the atte detached for	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnant at time of de 9☐Unknown		Other (specify)			Month	Day Year
Δ.	sign sign d be	by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.		bacco use contribute es 2□No 3□	to the cause of death? Probably 4 VUnknown
Il Records,	The law ate has t page 2 s	Completed							ry prior t med? death 2 No 1 □ Y	
f Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 Inpatient 2	ER/Outpaties	nt 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho		ne) ence 6 □Other(S	pecily)
ion of	Attending Ph ir death. ector: After th by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	y at k? Yes 2 □ No	28d. Discribe he	ow injury occurred	
Division	after dea Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location (S. City or Town		Rural Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Medicai C	29a. Certifier (Check only one) 2 Medical Examination and title of continuous	sician: To the best of my kno ner: On the basis of examinal and manner stated.	wledge, deat tion and/or in	vestigation, in my o	pinion, death occur	red at the time, o	late and place, and o	onth, Day, Year)
,	3		30. Name and address of person who co	impleted cause of death (Item	23a) (Type,	Print) 2 20 0 5	30661 more,	500	April - 212	39.
	St	ate	Stot Loch K 31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	Never	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	700		- /
	Regist	rar	APR 0 6 2004	frage was	7 1	poets				

December Name (Frex Medice, Law) RHIDREEKUS T. JONES 48. County of Death As County of	4. cri	-02141 n		Please 1 - For Unpend Item #23c	State of Ma ,21,28a f pe	ryland / De		Health and M	lental Hy			10330	
RRIDREKUS T. JONES RRIDRE)				2. Date of De	aath	Vaar	3. Time of Death	
Security of Death Security Number Security				RHIDREEKUS T. J	ONES							3:01 A ^M	
Social So				4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c.	County of Deat	h	
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Surgiciant Sur	<u>a</u>	Wenta Wenta rrked		RUSSELL JONES				HYVETI	E COLE	MAN			
Surgiciant Sur	<u></u>	and lame		19a. Informant's Name/Relationship (7	ype, Print)	19b. Ma	tiling Address (Stree	t and Number or Run	al Route Numb	er, City or	Town, State, 2	lip Code)	
Surgiciant Sur	, •	and sealth		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City									
21 Sgraphus eff uneral Service Towards of Jacob Control of Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 22 Symptocon as a consequence of the cause of death of the caus	ב כ	Jes 1											
23a Part force the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, including a death of the white a death		tmen tent:		`4 □ Donation 5 ☑ Other (Specify)								
23a Part force the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, including a death of the white a death	0	Separ Thoor Thy in		21. Signature of Funeral Service Lice	SALA A								
Projection / Modical Examinor Sequentially list conditions		40240		23a Part 1 Enter the disease or come	lications that caused t						u, ma		
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TA(W M, 1744) M.D. 111 Penn Street, Baltimore, Maryland 21201	0	ificate or. pa		25 Was case referred to medical				26 Place of Deat			1 X Yes	2 ∐ No	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TA(W M, Titus M.D. 111 Penn Street, Baltimore, Maryland 21201		To t To t	Σ	29b. Signature and title of Certifier	1 //		29c. Licen						
JACK M. Titus M.D. 111 Penn Street, Baltimore, Maryland 21201				P 4/1	VICE			O.C.M.E.		Marc	11 28, 2	UU4 	
24 Day Eled (Marth Day Vard)				30. Name and address of person who	completed cause of de			91 =	7.		,	21201	
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Registrar

APR 0 6 2004

ORIGINAL

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RJ	_		Registrar 1. Decedent's Name					eruncate (ט וט	eam	2. Date of		0.	3. Time of Death
	Physici		MARY <		KING						Month	Da	ау Yea 2004	
	/Medic Examir				give street and number)			4b. City, Tov	vn, or L	ocation of Dea			c. County of De	
9			2545 Pá	ark Heig	hts Terrace	è		Ba	alti	more		į	กไ	A
345	Funeral Director		5. Social Security N 142 · 54 · 8	967		e (In yrs. 8	last birthda Yrs.		ays	If Under 24 Hr Hours Mir		Birth Day Year,	9.8	irthplace (State or Foreign Country) NJ
	and w		Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or	Location						10d. Inside City Limits
	Mary -f sho	tor	MD	N	A	BAI	mmo	RE						1 MYes 2 □ No
	should be filed within 72 hours after death with the Maryland not Mental Hyglene. Is marked other then "natural", or items 23a or 28a-f show unafte event, the Medical Exerting traist by nuffied at	al Director	10e. Street and Nu	mber UNK	was			10f. Zip Co	de		unk	10g. Ci	itizen of What C	Country?
10	72 hours after deati "naturel", or ttems 2	Funeral	11. Marital Status	ied 2 ☐ Marrie	12. Was Decedent Armed Forces?		J.S. 13	If Yes, specify	of Hisp Cuban,	panic Origin? (Mexican, Pue	Specify Yes or rto Rican, etc.)	No-	14. Race - An Bleck, Wi	
936	al', or	by	3 Widowed		If Yes, Give Year or Dates:			1 ☐ Yes 2 🔀	No	Specify:			Specify:	BLACK
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ary	should be and Menta a marked umatic ev	-	19a. Informant's Na	ame/Relationship	(Type, Print)		19b. Ma	iling Address (St					or Town, State	. Zip Code)
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ore	of He fitter		20a. Method of Disp		☐Removal from State	20b. F	Place of Dis	oosition (Name o	of		Date		ocation - City o	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic <u>once.</u>		* 4 □ Donation	5 Other (Spe	cify)	1	JT. 2	•		04	06/04	BA	LIMO	e, MD
Bal	permit. Depart Import any inj		21. Signate of Fu	1/ -	en en en en en en en en en en en en en e			Name and A VAUGHN C 5151 BAL	ddress O A	OF Facility SEEIVE 1	FUNERAL KE. BAL	SER	NICE	229
68760,	eath certificate be executed attending physician and for use as the burial-transit	Ilcai Examiner	snock, or nea Immediate Cause disease or conditio resulting in death) Sequentially list co if any, leading to cause. Enter Unde Cause (Disease or that initiated events resulting in death) i	(Final on moditions, moditions, moditions, moditions, modified by the control of	a. Cardiac Due to (or as b. Myocardia Due to (or as c. Due to (or as d. Due to (or as	arrhy a conseq al fil	thmia puence of): prosis puence of).							Interval Between Onset and Death
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	To: To 1	Σ	29b. Signature and	41	N. At			29c. Lic	ME			Maı	te signed (Mon rch 27,	2004
			OFFICE	11/4 ///	o completed cause of de			Print) 111	Peni	n Stree	et, Balt	imore	e, Mary	land 21201
	Sta		31. Date filed (Mon.	th, Day, Year)	32. Registra									
DH	Registr VH 17 Rev 1/20	-	ΔI	PR 0 6 2	104 Starce	a. S.	fo	Call !						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State of	waryia		artment of t rtificate of		мена пу	Reg. No. 20	04	10332
	Physici		1. Decedent's Name (F	First, Middle, La	st)					2. Date of De Month		Year	3. Time of Death
	/Medic	al	LYDIA			'IAT				APRIL 3			4:30 AM
Ž	Examir	er	4e Fecility Neme (If no MANOR CAR			nber)			4b. City, Town, o POTOMA	r Location of Deet C	h 4c. County of MONTGO		
	Funeral Director		5. Social Security Num 054 - 34 - 11	84 1	ex □M 2√xF		: last birthday) 1 Yrs.	If Under 1 Year Months Days			rth ay, <i>Year)</i> 912	9. Birthp Coun ENGI	lece (State or Foreign try) _AND
	pur *	-	Usual Residence of De 10a. Stete 10	ocedent Ob. County		10c. C	ity, Town or Lo	cation				10	0d. Inside City Limits
	Manyle f sho	6	MARYLAND	MONTGOME	RY	,,,,,	POTOMA					"	1 ☐ Yes 2√ No
-	28a	5	10e. Street end Numbe					10f. Zip Code			10g. Citizen of W	het Coun	
3	23a o	Funeral Director	10714 POTOMA	C TENNIS	LANE			208	354		USA		
	dear dear	ne.	11. Maritel Stetus		12. Was Dece	dent Ever in I	J,S. 13. \	Was Decedent of I f Yes, specify Cub		Specify Yes or No		- America	an Indian,
020	s 1 and 2 should be filed within 72 hours aftar death with the Maryland fleatilt and Mental Hygiens. If Heatilt and Mental Hygiens of them 21a naticed other than "natural," or itama 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married ③ Widowed 4 ☐		1 ☐ Yes If Yes, Give Year or Da	ON KJK		1 □ Yes 2 No		no modi, etc.,	Specify:		
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21215-0020	within iena. than	Completed	Elementery/Secondar		College (1-	4or 5+)	life. l	<i>DO NOT</i> use <i>retir</i> e MEMAKER	d)	9	IWO	N HOME	
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Maryland	Ments Ments arked arked	P	ISREAL		SPRINGER				MOL	LIE	GOLDFI	NE	
Jar	2 sh and to me	- 7	19a. Informant's Name								er, City or Town, S	State, Zip	Code)
	1 and Health Sm 27 ther t	1	STEPHEN KIV 20a. Method of Disposi		N .	20h		4-A E. 36t sition (Name of	th SIREEI,	NEW YORK,	NY 10016 20c. Location - C	ity or To	un State
Baltimore,	0 0		1 ☐ Burial 2 [2](& 4 ☐ Donation 5 [remation 3		tate		natory or other pla		4/6/2004			
	permit. Pag Department Important: I any injury c	1	21. Signature of Funera)		. Name and Addre			BALTIMOF MORTUARY SU		
10	2011		KELIKO	BECORY EI	NK #M0114	g g	4:	26 CRAIN HI	IGHWAY S,		E, MD 21061		
		\forall	23a. Partil. Enter the c shock, or heart fa				th. Do not ente	er the mode of dyin	ng, such as cardia	ac or respiratory a	rrest,	1	Approximate Interval Between
	hysician /Medical							- /	1			1	Onset and Death
	Examiner		Immediate Cause (Fina disease or condition resulting in death)	aı	a. H	eav		Faile	ine				Iwh.
W.		ner			00	Per no	or es a conseq	uence of):	101	1 . 500	20 - 0		-01
000	ocuted ind transi	ami	Sequentially list conditi	ions,	b	Due to (or as a conseq	uence of):	79	0/200	need		0-14
ဂ္ဂ	ficate ba executed physician and is the burial-transit	edical Examiner	Sequentially list conditi if any, leading to imme cause. Enter Underlyir Cause (Disease or inju- that initieted events	ng Iry	c. Ql	the	wsc	lew.	Jes	adva	need		old:
68760,	tificate ba executed ig physician and as the burial-transit	edic	that initieted events resulting in death) Last	1		Due to (or as a consequ	uence of):				į	
X P	in cen tendin r use	Physician/N		-	d								
j. 5	e dea the at hed fo	13	Part II. Other significan	nt conditiona co	ontributing to dea	th but not res	sulting in the ur	nderlying cause giv	ren in Part I.	23b. Did	tobacco use cont	ribute to	the cause of death?
ָרָי נְּיִיּ	iaw requiras mai me deam ceminas been signed by the attending a 2 should be detached for use at									10	Yes 2□No	3 🗌 Prob	ably 4 Unknown
Hecords,	equira: sen sig ouid b	Completed by									an autopsy	ava	re autopsy findings ilable prior to
ecci	has be a 2 sh	nple											eath?
<u> </u>	nysteram: The raw his certificata has t I director, paga 2 s	ខ								10	Yes 2000 XVo	1 🗆	Yes 2□No
VITAI	this certific ral director,	o Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☼ ੴNo	+	Hospital:	patient 2	150/0-45-4	Oth		ath (Check only o		(5)	
	ar this eral di	⊢⊢	27. Menner of Death		28e. Date of		28b. Time of	t 3□ DOA 28c. Injur Wor			dence 6 Other	-	,
VISION	ath. or: Afta ha fun	atio	2 Accident	Pending investigation		, Day 19ai)	Injury		Yes 2 □No				
= >	at or Augmoing Frost attacked at the Common State of the Common St	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	GOUID not be determined	288. Piece 0	of Injury - At h g, etc. <i>(Sp</i> ec <i>i</i>		et, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	r or Rural	Route Number,
T letter	vithin 24 hours aftar de To the Funeral Directo completely filled in by th		29a. Certifier	Certifying Phy	/sician: To the b	est of my kno	wledge, death	occurred at the tir	ne, date and plac	e, and due to the	cause(s) and man	ner as ste	eted.
1	in 24 the Fu	edical	one)		inar: On the bas and manne	is of examina or stated.	ation end/or inv	estigation, in my o	pinion, death occ	urred at the time,	date and place, an	nd due to	the cause(s)
, e	t t E	2	29b. Signature and title	of certifier	. 011			29c. Licens	e number		29d. Date signed		lay, Year)
			PVO	Ubel	of No)_		D	313	17.	APRIL 5,	2004	
	2		30. Name end address	of person who o	completed cause	of deeth (Ite	m 23e) (Type, F	Print)	2 - 7	- 20	1 1/		
Ø 80	Sta	e .	31. Date filed (Month, D	CENNI) Day, Year)	/ 32. Re	gistrar's Sign	etuto 1	erint)	ND	208	7.		
	Registra	.6	APR 0	6 2004	Denne	1	4 A	could					

			For State Registrar	State of Maryland /	Department of F		ental Hygie	/ 1111 6	10333
ń	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Ernest, V. G	-	ansa	12.0	2. Date of Death Month A pril	Day Year	
	Examin uneral irector			O Kins Hospita 7. Age (In yrs. last b	1 Baltim		8. Date of Birth (Month, Day, Ye	4c. County of Dee	thplece (State or Foreign
G Z IZ 13-0030 filed within 72 hours after death with the Maryland	na rypure. do other than "natural", or items 23s or 28s-f show seent, the Medical Exerciper must be notified at	Funeral Director	NOONG/UPPER HI	nce House-1st	wn or Location A Rob Floor 10f. Zip Code O O 1 13. Was Decedent of If Yas, specify Cub	dispanic Origin? (Spe		Citizen of What Co	10d. Inside City Limits 1 Yes 2 No suntry?
in 72 hours after	n "natural", or ital feologi Exercitor	Completed by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade	completed)	If Yes, specify Cub 1 □ Yes 2 No ia. Decedent's Usual Occu (Give kind of work done (iffe. DO NOT use retire	Specify: pation during most of working	166	Black, White Specify: B	lack
should be filed with	2 0 6	To Be Comp	17. Father's Name (First, Middle, Last) A. L. Kwans	College (1-4or 5+)	ublic Heal	Victor	CER. Pak (First, Middle, Maid Ta Ac	ldo	Federation
ore, Ma	or nearth ar		19a. Informant's Name/Relationship (Type 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	omoval from State 20b. Place comet	ot Disposition (Name of tery, crematory or other pla	Om 4-24	ate 200	Location - City or	Town, State
Ph	ysician		23a. Part1. Enter the disease, or compliants of compliants of compliants of compliants of compliants of compliants of compliants of compliants of compliants of compliants of compliants of condition compliants of	a ons that cause the death. Do cause on each line Pancreatic A	denocarcin	ng, such as cardiac o		100 212	Approximate Interval Between Onset and Death months
be executed W	Medical and prize	ical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence	e of):				
.O. BOX 687 the death certificate	ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		у		23d. Date of de Month	ivery Day Year
w requires that	sign d be	by	Part II. Other significant conditions con	ributing to death but not resulting	g in the underlying cause gr	ven in Part I.	23e. Did tobac		o the cause of death?
The law	ate has page 2	e Completed	25. Was case referred to medical			26. Place of Death	24a. Was an autopsy performed 1 Yes 2 1	rior to death?	utopsy findings available completion of cause of
sion of Vital	this aldi	To B	examiner? 1 Yes 2 No 1. Manner of Death 1. Naturel 5 Pending 2 Accident investigation		o. Time of 28c. Injury Wo	her: 4 Nursing Hon	ne 5 Residence		city)
DIVISION spital or Attending	b b	il Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)			28f. Location (Stree City or Town, S	tate)	
To the Hos	within 24 hours at To the Funerel Di completely filled in	Medical	(Check only one) 2 Medical Examination (Check only one) 2 Medical Examination (Check only one) 29b. Signature and title of certifier	er: On the basis of examination and manner stated.	and/or investigation, in my	opinion, death occurre se number	ed at the time, date	and place, and due Date signed (Mont	h, Day, Year)
	6		30. Name and address of person who con Deidra C. Crews	us M.D. npleted cause of death (Item 232 600 North	a) (Type, Print)	5-000 et Balti			
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 6 2004	32. Registrar's Signature		,	11016,101	Joseph Carll	-1201

				a,pState,of Ma	r ville 19839 4 C	ertificat	te of l	Death		2. Date of De	Reg. No.	2004	
Physic	an	Decedent's N	ame (First, Middle, La	st) aig Kidwel:	7					Month		$20\overset{\text{Yeer}}{04}$	3. Time of Death
/Medi	cal	4 5 % No.			<u> </u>	4b Cin	Tour or	Location of	of Dooth	April		2004 ounty of Death	20.00
Examir	ner		e (If not institution, giv Paulette Ro			4b. City,		Dunda.			40.0	Baltim	
	F-7	5, Social Securit			(In yrs. last birthda		r 1 Year	If Under		8. Date of Bi	rth		
Funeral Director		218-74- Usual Residence	9959	X 2 □ F	46 Yrs	Months	Days	Hours	Min.	8. Date of Bir (Month, Di Feb. 2	8,195	8 Mary	place (State or Foreign nary) Land
nand name		10a. State	10b. County		10c. City, Town or	Location							10d. Inside City Limits
Many Many Miled	tor	Md.	Baltimor	e	Dund	alk							1 ☐ Yes 2√ No
with the 3a or 284	i Director	10e, Street and	Number 2011 Paul	ette Road			222				-	on of What Cou	intry?
death me 2	Funerai	11. Marital Statu	ıs	12. Was Decedent E	ver in U.S. 1	3. Was Dece	dent of H	ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	0- 14	Race - Amer	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Heme 23e or 28e-f show summatic event, the Medical Examinational be regulified at	þ		larried 2 Married	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	lo	1 Yes, spe		Specify:	i, Pueno	rican, etc.)		Black, White Specify: Whi	
5-0	ted	/9	15, Decedent's E pecify only highest gr	ducation	16a. De	cedent's Usu	al Occup	ation during mos	t of worki	na	16b. Kind	d of Business/li	ndustry
Ind 21215-0036 be filed within 72 hours at lal Hygiene. d other than "natural", or event, tre Medical Exern	Completed		econdary (0-12)	College (1-4or 5-	+)	Disab		0				None	
e file al Hys	Be	17. Father's Nar	me (First, Middle, Las)				18. Mothe	er's Name	(First, Middle	, Maiden S	umame)	
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> = = > =			s Name/Relationship idwell - B							stown,		Town, Stete, Zi 21136	ip Code)
other tra		20a. Method of	Disposition		20b. Place of Discemetery,	rematory or i	other place	e)		ate	20c. Loca	ation - City or T	own, Slate
Page Page nent c			26 Cremation 3 Don 5 Other (Speci		Metro	Cremat	ory	Apri	1 5,	2004	Balt	imore,	Md.
Baltimore, I permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other once.		21. Signature	Funeral Service Lice	a de		22. Name a Eckha	nd Addres	ss of Facilit	al C	hapel,	P.A.	. Mills	21117 Ma
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and properties.	dical Examiner	Immediate Caudisease or con resulting in dea Sequentially lis if any, leading cause. Enter Ucause, (Diseas that initiated ev resulting in dea	ise (Final dition th) t conditions, o immediate inderlying or injury ents	b. Due to (or as a	a consequence of): a consequence of): a consequence of):	ia							Interval Between Onset and Death
P.O. Box 6 nat the death certific d by the attending letached for use as	Physician/Medi	IF FEMALE: 23b. Was dece in the pas 1 ☐ Yes 9 ☐ Unknown	t 12 months? 2 □ No	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s _i					23	d. Date of delive Month	r ery Day Year
ds, Puires that signed I			•	contributing to death bu scular diseas	•	e underlying	cause giv	en in Part I.			tobacco use Yes 2 🗆		the cause of death? bably 425Unknown
Vital Record siclan: The law requir certificate has been s lirector, page 2 should	Completed by						-			24a. Was auto perf 1 Yes	omed?	24b. Were aut prior to co death? 1 Des	opsy findings available ompletion of cause of
Vite iclan: sertific ector,	Be	25. Was case r examiner?	eferred to medical	Hospital:			OA Oth			(Check only			
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Division of Vital Records, To the Hospital or Attending Physician: The law requires t within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	Certification:	2 Accide 3 Suicide 4 Homic	nt investigate	De Place of Init	ury - At home, farm, c. (Specify)	M street, factor		Yes 2□			(Street and iwn, State)	Number or Rui	ral Route Number,
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To th Within To th	Me	29b. Signature	and title of certifier			29	c. Licens					signed (Month	
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				completed cause of de		oe, Print) 1 Penn	Str	eet,	Balt	imore,	Mary]	land 21	201
St Regist	ate	31. Date filed (Month, Day, Year)	0 6 200	ar's Signature	de de	A COLOR	, a					

State of Maryland / Department of Health and Mental Hygiene 10335 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:10a.m March 30, 2004 Ε. Kessler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Augsburg Lutheran Home Lochearn If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 18, 1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2₹ F Days Hours 168-30-4432 87 Vrs Pennsylvania Director Usual Residence of Decedent with the Maryland 10d, Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. Maryland Baltimore Lochearn 1 ☐ Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6811 Campfield Road 21207-4698 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Clarence B. Diehl Hermia M. Runkle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brian Kessler (Son) 17 Elizabeth Street, Binghamton, New York 13901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State
1 Donation 5 Other (Specify) Baltimore Washington Crematory April 2, 2004 Laurel, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityLoring Byers Funeral Directors, 8728 Liberty Rd., Randallstown, MD 21133-4784 ollner Moo333 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician FAILUNE TO /Medical Due to (or as a consequence of) **Examiner** ALZHIEMER PEMENTIA Zweeks STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached t 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 donknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 140 24a. Was an page 2 s 1 Yes 2 No certificate To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ this After thi 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗋 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Detrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Diene March 31.2004 Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD ZIZO8 7220 IMAGHTS AVENUE U6borah I. 31. Date filed (Month, Day, Year)
APR 0 6 2004 32 Aegistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2004 **Physician** Robert M. King March 31, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Stella Maris Hospice Timonium Baltimore County If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 214-38-9890 Yrs 1939 64 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State d other than "natural" or iteme 23a or 28a-1 show event, tra Medical Exp. is arrunal be notified at 1XXYes 2 □ No Maryland N/ABaltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1404 Medfield Avenue 21211 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes **2(13)** No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 🎗 🖫 Married 21215-0036 1 ☐ Yes XX No Specify. white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done di life. DO NOT use retired) during most of working US Army Corps Elementary/Secondary (0-12) College (1-4or 5+) Engineering Electrical Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Pages 1 and 2 should be Maynard King Virginia Wheat 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1404 Medfield Avenue Patricia King Wife Baltimore, Maryland 21211 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial 4/3/04 | Cockeysville, MD * 4 □ Donation 5 □ Other (Specify) Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21211

Approximations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Rolling in death)

Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21211

Approximations are such as cardiac or respiratory arrest, interval Rolling in death)

PANCREATIC CANCEP **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ cate has been signing page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 COther (Specify) HOSPICE Hospital: 1 ☐ Yes 2 ▼ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident the Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number di 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dr. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 2004 32. Rigistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month KUNTZ 19:19 MARIO 30 MARCH 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

MAY 17, 1933 VIrgin Gorda 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 M 2□F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 No JOHN Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 00831 VIrgIN Gorda - ruz Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SANITATION Worke 17. Father's Name (First, Middle, Last) Be Kuntz 2 hola 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Angela 20a. Method of Disposition 302083, 5++ 00803 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License mo1148 Home Funeral 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List phy one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final disease or condition resulting in death) Failure Denal Houte Zdays Due to (or as a consequence of): Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Mediastinitis Due to (or as a consequence of) Artery Physician/Medical Coronary Disease IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 4 Donknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autoosy findings available 24a Wasan

The law requires that the death certificate be executed use as the burial-transit and been signed by the attending physician Division of Vital Records, P.O. Box 68760 į detached should be page 2 has this certificate Hospital or Attending Physician: completely filled in by the funeral director. After death within 24 hours after deatl To the Funeral Director:

Physician

Funeral

Director

or 28a-f show

or items 23a

"natural".

ie marked other than

permit. Page Department o Important: If any injury or once.

Physician

/Medical

Examiner

. Pages 1 and 2 should be fitteent of Health and Mental Htant: If item 27 is marked of

or other traumatic event, the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

							autopsy performed? 1 ☐ Yes 2 🔏 N	prior to completion of cause of death? 1 Yes 2 No
25	. Was case referred to m	nedical				26. Place of Dea	th (Check only one)	
	examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA	Other: 4 Nursing H	ome 5 Residence	6 ☐Other (Specify)
27		Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred
		Could not be determined			t, factory, o	ffice	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number. te)
29			nysician: To the best of my kr miner: On the basis of examination					s) and manner as stated. nd place, and due to the cause(s)

29b. Signature and title of certifier Chatylin Gelvill 29c. License number RES - 000

29d. Date signed (Month, Day, Year) 2004 MARCH 30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, M.D. boo North Wolfe Street, BALTIMORE MARYLAND Christopher 6. Williams

State Registrar

31. Date filed (Month, Day, Year) APP 0 6 2004

32. Registrar's Signature

and manner stated

MD

2

	•	State Registrar	ite of Maryland	/ Depa <i>Cen</i>	rtment of He	ealth and I Death		iene 20	04 103	38
Physicia /Medic Examin	al .	1. Decedent's Name (First, Middle, Last) SUSIC 4a. Fecility Name (If not institution, give street)	and number)		King 4b. City, Yown, or I	21	2. Date of Deat Month	Day 29 200	f Death	ith 2 м
Funeral Director		5. Social Security Number 6. Sex 1 M 2 Usual Residence of Decedent	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08–22–19	Year)	9. Birthplace (Stete or Fo Country) Kentucky	reign
ne Maryland 8a-f show	Director	10a. State 10b. County Md N/A		Town or Loc	re				10d. Inside City Li	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic svent, the Medical Examination manable and	by Funeral	1 Never Married 2 Married 1		Ifa. Decede	10f. Zip Code 21215 as Decedent of His Yes, specify Cuban Yes 2270 ont's Usual Occupating of work done di	Specify:	pecify Yes or No- o Rican, etc.)	Black,	- American Indian, White, etc. Black	
Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mental Hygiene. It is marked other than "natural", or traumatic avant, the Medical Evant traumatic	To Be Completed	Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last) William Daniels 19a. Informant's Name/Relationship (Type, Pr	int)			18. Moth <i>e</i> r's Nar Ruth	ne (First, Middle, M	faiden Surname,		
imore, Ma Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra		Andera King 20a. Method of Disposition 1 Burial 2 Scremation 3 Remove 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	al from State cem	e of Dispos etery, crem	ition (Name of atory or other place sh. Crema	tory 4/2	Date 2/2004 L	aure1, l	yland 21205 ity or Town, State Maryland al Directors	- Т-
M &&E & & & & & & & & & & & & & & & & &		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	s that caused the death. I se on each line. Lefastafic	872 Do not ente	28 Libert	y Road I	Randallst	own, Mar	ry1and 21133 Approximate Interval Between Onset and Deat	3 n
Medical Examine pe executed shysician and the burial-transil	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or ás a consequen Due to (or as a consequen	nea of).						
the death certific ty the attending price as	by Physiclan/Medical	in the past 12 months?	res, outcome of pregnancy Live birth 2 □ Fetal de □Pregnant at time of death □ Unknown	ath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date Monti		-16
Cords, P		Part II. Other significant conditions contributi	ng to death but not resultir	ng in the und	derlying cause giver	n in Part I.			oute to the cause of death	
	Completed				**			prided? de:	ere autopsy findings avail or to completion of cause ath? Yes 20 No	able of
Of Phys this al dil	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospita 27. Mann of Death 1 Atural 5 Pending 2 Accident investigation	1 Unpatient 2 ER	VOutpatient Bb. Time of Injury	3□ DOA Other 28c. Injury a Work?	4 □ Nursing H	ome 5 Resider 28d. Describe ho	nce 6 Other		
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined 286	. Place of Injury - At home building, etc. (Specify)				City or Town	State)	or Rural Route Number,	
To the Hospital within 24 hours & To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 2□ Medical Exeminer: One) 29b. Signature and title of certifier				nion, death occu	rred at the time, da	te and place, an		
F 3 F 3		30. Name and address of person who complete	elsen MD ed cause of death (Item 23	3a) (Type, P	RES	000			29, 2004 D, 2123,	
Sta Registr		Michael A. W. Sen 31. Date filed (Month, Day, Year) APR 0 6 2004	MD 5601 32. Registrar's Signature	Lock	Ravin	Bhol,	Baltime	The M	0, 2/23,	9

111.1			State 1 - State Impend Item#23a, PartII, 2	of Maryland / Depa 7,PerMEG830,4 <i>G</i> (0	artment of Health and N	fental Hygie	ne 2004	10339
	Dhysisi		Decedent's Name (First, Middle, Last)	. (, M	2. Date of Death	Day Year	3. Time of Death
	Physici /Medi		KEVIN MICHAEL K	ELEY		MARCH 25		2:30 P M
	Examir	ner	4a. Facility Name (If not institution, give street and n		4b. City, Town, or Location of Death		4c. County of Death	
7	F		762 Quince Orchard Blvd 5. Social Security Number 6. Sex	1 7. Age (In yrs. last birthday)	GAITHERSBURG If Under 1 Year If Under 24 Hrs.	8 Date of Birth	MONTGOME 9 Birth	RY CO plece (State or Foreign
	Funeral Director		523-04-0743 18M 20F	46 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 3-17-16	ar) Cou	iANA
)	D .		Usual Residence of Decedent	10.00				
	the Marylan 28a-f ahow notified at	5	10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28s-f	rect	10e. Street and Number	Y GAITHE	10f. Zip Code	100	Citizen of What Cour	
	3a or	0	762 QUINCE DOCK	ADN ALVO.	20278		1). L.A	•
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ahow ha Madical Examinar usuit be trailified at	Funeral Director	11. Marital Status 12. Was De Armad I	cedent Ever in U.S. 13. \	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Rece - Americ	can Indian,
98	or the	y Fu	1 Never Married 2 Married 1 Yes	2 No	Tes, specify Cubarr, Mexicarr, Fuerto	riicair, etc.)	Black, White,	erc.
215-0036	hours tural	ed by	3 ☐ Widowed 4 ☐ Divorced Year or 15. Decedent's Education	Dates: 1975-78	lent's Usual Occupation	1.00	W	MILE
15	n na	plet	(Specify only highest grade completed	f) (Give	kind of work done during most of work DO NOT use retired)	ing	. Kind of Business/In	dustry
212	d with giene er the	Completed	College	(1-40r 5+) HOME	IMPROVEMENT	- C	ONSTRU	SCTION
pu	ould be filed with Mental Hygiene. arked other that atic event, the	Be (17. Father's Name (First, Middle, Last)	11-11-1	18 Mother's Name	(First, Middle, Maid	len Sumame)	
Maryland	should nd Men marke umatic	2	FREDERICK JOSEPH	KELLEY	JOY EL	AINE I	MER	
Mai	s 1 and 2 should be tited within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 ahov other traumatic event, the Medical Examinar must be mutified as		19a. Informant's Name/Relationship (Type, Print)	LIEND 1626	g Address (Street and Number or Run	1.11 -2	ly or Town, State, Zip Q: 🌃 🗓 🗸	Code)
ā,	s 1 and t Health ttem 27 other tr		20a. Method of Disposition	20b. Place of Dispo-	sition (Name of		Location - City or To	own, Stete
Ê	Pages nent of int: If it		1 ☐ Burial 2 ★Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State BAVIED	PEMATIRY 4-2	-04 RA	LTIMORE	MD.
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Mande.		21. Signature of Funda Service License	22	. Name and Address of Facility	110	-	
00	89 8 9		X-1-Xohm		Daugherty Family Funeral Ho 2601 Mountain Road	Pasadena MD	n Center, P.A. 21122	
35			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on					Approximate Interval Between Onset and Death
1	Physician /Medical		resulting in death)		erotic Cardiovascular	Disease		Onset and Death
11	Examiner		Due to	o (or as a consequence of):				
	16 A	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequence of):	4			
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90,	cate be executed physicien and the burial-transit	EX	resulting in death) Last Due to	o (or as a consequence of):				
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Box 6	leath certific attending plater use as t	J/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, o	utcome of pregnancy			23d. Date of delive	an/
	death e atter	Physician/M	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year
P.0	at the de by the stached	hys	9 ☐ Unknown 9 ☐ Unk					
	res tha igned be del	þ	Part II. Other significant conditions contributing to Chronic Drug Abuse	death but not resulting in the un	derlying cause given in Part I.		o use contribute to the	
oro	w require been si should t	eted	Citatic Big house			1 Yes	2 No 3 Prob	ably 4 Unknown
Vital Records,	hast pe 2 s	Completed				24a. Was an autopsy performed	prior to cor	psy findings available npletion of cause of
la I		e Co	25. Was case referred to medical			1 TorYes 2 □ 1		2□ No
>	Physician: this certitic ral director,	0 8	examiner?	Inpatient 2 ER/Outpatient	26. Place of Death 26. Place of Death Other: 4 □ Nursing Hor		6 X]Other (Specify	SCENE
o of	ding Ph. h. Atter thi tuneral	T:uc		of Injury 28b. Time of Injury Injury		28d. Describe how in		/ SCENE
Siol	Attending r death. ector: Atter by the fune	catic	2 Accident investigation	, , , , , , , , , , , , , , , , , , , ,	M 1 Yes 2 No			
Division	or At atter d Direct in by	Certification;	determined 208, Flat	e of Injury - At home, farm, stre ding, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, Sta	and Number or Rura ate)	I Route Number,
	To the Hospital or Attent within 24 hours atter death To the Funeral Director: completely filled in by the		29a. Certifier 1 ☐ Certifying Physician: To the	e best of my knowledge, death	occurred at the time, date and place,	and due to the cause	(s) and manner as et	atad
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Examiner: On the	basis of examination and/or inv nner stated.	estigation, in my opinion, death occurr	ed at the time, date a	ind place, and due to	the cause(s)
	To th withir To th comp	Ĕ	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, I	Day, Year)
			My Ni. M.D		ОСМЕ	I	MARCH 26,	2004
			30. Name and address of person who completed car	use of death (Item 23a) (Type, F		D 7/1		7 04004
	Sta	to	31. Date filed (Month, Day, Year) 32.	Registrar's Signature	111 Penn Street	, Baltimo	re, Maryla	ind 21201
3.	Registr			to speech	,			

	1	For State Registrar	State of Maryland		artment of Hortificate of L			Reg. No.	2004	
Physician	_	Decedent's Name (First, Middle, Last Charle		KELLE	D		2. Date of De Month March	Day	Year 2004	3. Time of Death 10:59 PM
/Medical Examiner	. a	Ia. Fecility Name (If not institution, give		KELLE	4b. City, Town, or	Location of Death	1		County of Death	10:59 1
Examiner		Holy Cross Hospit	al		Silver S	pring		1	Montgome	ry
Funeral Director		5. Social Security Number 6. Se		as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March	rth ay, Year)	9. Birth	place (State or Foreign ntry) York
tryland show		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2√∑ No
r 28e-f a	-	Maryland Montgom 10e. Street and Number	ery Si	llver	Spring 10f. Zip Code			10g. Citi:	zen of What Cou	
23a o		9508 Seminole Str	eet		20901				ed Stat	
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland I ten at 2 should be filed within 72 hours after death with the Maryland I ten at 1 is marked other than "naturel; or Items 23a or 28e-1 show other traumatic event, the Medical Examiner must be rediffed at To Be Completed by Funeral Director		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ★Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ★No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		14. Race - Ameri Black, White, Specify: Whi	etc.
Maryland 21215-0036 d 2 should be filed within 72 hours aft at a marked other than "naturel", or traumatic event, to a Medical Evant To Be Completed by F	-	15. Decedent's Edit (Specify only highest grad		(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of wor	king	16b. Kir	nd of Business/In	dustry
ind 2121 be filed within tal Hygiene. d other than avent, tra Me		17. Father's Name (First, Middle, Last)	5+	Elec	trical En	gineer 18. Mother's Nam	ne (First, Middle	Depa , Maiden	rtment Sumame)	of Defense
ylandould be ould be Mental Marked o Ma		Philip Keller				Minna	Messing			
Maryland A2 should be in the and Mental. 27 is marked out traumatic even		19a. Informant's Name/Relationship (T			ng Address (Street a					
and and m 27 her tr		Philip Keller, So			Granville	Drive,	Silver Date		ng, MD 2 cation - City or To	
⊙ 8,2 ≥ 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery, cre	osition (Name of matory or other place id Memoria	04	/02/04		lls Chur	
Baltim permit. Pa Departmen Important: any injury		21. Signature of Funeral Service License	500	T	2. Name and Addres orchinsky 54 Carrol	Hebrew				012
Physician /Medical Examiner		23a. Par Lent r the disease, or comp shork or eart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Atherosclero Due to (or as a consequ	tic C	ter the mode of dying	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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760 te be ysicia	5	resulting in death) Last	Due to (or as a consequent	uence of):						
Il Records, P.O. Box 68 The law requires that the death certificat alte has been signed by the attending phypage 2 should be detached for use as the completed by Physician/Medi	yalcidinime	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			2	23d. Date of deliv Month	ery Day Year
that the ched by the detacher		Part II. Dther significant conditions co	ontributing to death but not resu	utting in the u	ınderlying cause give	n in Part I.	23e. Did	tobacco u	se contribute to t	he cause of death?
cords, wrequires been sign should be		Peripheral Vascul	ar Disease, De	ementi	a,		10	Yes 2[□No 3□Prol	oably 4 XUnknown
The law reate has be page 2 st	old line	Acute Protein/Cal	orie Malnutrit	ion			24a. Was auto perfo 1 \(\text{Yes}	psy ormed?	24b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available impletion of cause of
Vital F icien: Th certificate rector, pag		25. Was case referred to medical				26. Place of Dea				
Vision of Vital Attending Physicien: refors Alter this certified by the funeral director,	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 🖾 Inpatient 2 🗆 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury		er: 4 \(\text{\text{Nursing H}}\) \[\text{at} \\ \text{i?} \]	ome 5 Res 28d. Describe			(y)
in the second	ei IIIIcani	2 Accident Investigation 3 Suicide 6 Could not be determined				fes 2□No	28f. Location City or To			al Route Number,
Hospitel 24 hours a Funerel I etely filled	Medical		ysician: To the best of my kno niner: On the basis of examinal and manner stated.							
To the within 2 To the comple	ME	29b. Signature and title of certifier	luared MD		29c. License				e signed (Month.	
30		30. Name and address of person who can Robert H. Gerard.	completed cause of death (Item		Print) Glen Roa	d, Silve	r Sprin			
State		31. Date filed (Month, Day, Year) APP 0 6 2004	32. Registrar's Signa		loo del	,				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2014 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year REA LIEBNO April 02 2004 2:05 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Catonsville Baltimore St. Joseph Nursing Home 8. Date of Birth (Month, Day, Year) if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1□ M 2□XF 89 Yrs. 212-28-5971 June 12, 1914 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland Woodlawn 1 ☐ Yes 21 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6511 Windsor Mill Road 21207 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Transportation Taxi Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Arthur Shaw, Sr. Theresa E. Ring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Shaw / Brother 106 Coyle Avenue, Rumford, Rhode Island, 02196 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crestlawn Mem. Gardens 4/6/2004 Marriottsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscheotic Caedis vasculae Disease call Due to (or as a consequence of) type tengen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Celebro vas cular 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth? 2 No 1 ☐ Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

/Medical Examiner ed by the attending physician end datached for use as tha burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 ate has been signed page 2 should be dat To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate i completaly filled in by the funeral director, pag

Physician

/Medical

Examiner

Directo

Funeral

Be Completed by

Funeral

Director

7 is marked other than "naturel", or flems 23s or 28s-f sho traumstic event, the Medical Examinar must be notitied at

permit. Peges 1 and 2 should be filed within 72 hours after deeth with 1 Department of Haalth and Mentel Hygiena. Important: If Item 27 is marked other than "naturel; or Hema 23a or any injury or other traumatic event, the Medical Examines must han

Physician

Examiner

Physician/Medical

۾

Completed

Be

10

Certification:

edical

Baltimore, Maryland 21215-0036

the Marylend

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Mapner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821 N. Entaw Steet, Suite 407, Baltimuse MB 21201 Jyotin Tarikh M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature

D32158

3/04

State Registrar

6 2004

			. For	State of Marylan				-	giene	
		,	1 - Stete Registrar		Cei	rtificate of	Death		Reg. No. 200	
	Physicia	an	Decedent's Name (First, Middle, Last,					2. Date of De.	Day, Yee	3. Time of Death $5:40 \text{ AM}$
	/Medic	al	Roy Lee Lat 4a, Facility Name (If not institution, give	WSON		4b City Town	or Location of Deat	1	3/1 200 4c. County of De	/
	Examin	er	MARINER HEALT	mot BELAI	R	he/	AIZ	•	HAVFO	rd
	Funeral		Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt	th 9. B	Birthplece (State or Foreign Country)
	Director		229-18-1705	XM 2□F 79	9 Yrs.	Months	Tiodis Iviai.		3, 1925 Vi	
	and W		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Maryl	tō	Maryland Harford	A	berdee	n				1 ∐ Yes 2XX No
	n the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	death with the Maryland ms 23a or 28a-f show r must be notified at	ralD	917 Stepney Road	South		21001			USZ	
	ar dea	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of his Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No o Rican, etc.)	14. Race - Ar Black, Wi	merican Indian, hite, etc.
0000	hours after tural', or its	by F	1 Never Married 2 Married 3 Never Married 4 Divorced	1 XYes 2 □ No If Yes, Give Year or Dates: 1942-	_A E	1□Yes 2XNo	Specify:		Specify:	nite
ž			15. Decedent's Edu	ication	16a Dece	dent's Usual Occup	pation	diag	16b. Kind of Busines	
7	within 72 ene. than "na!	Completed	(Specify only highest grad	College (1-4or 5+)			during most of wo d)	King		
7	led wi lygien her th		9 17. Father's Name (First, Middle, Last)		1	<i>Mechanic</i>	19 Mathada Na	no /First Middle	Shoe Manu Maiden Sumame)	ufacturing
and	d be findal Hed ot	Be						_		
	should nd Mer marke	2	Joseph Buckle: 19a. Informant's Name/Relationship (7)		19b. Mailir	ng Address (Street	Sarah and Number or Ru	Ann Iral Route Numbe	witt er, City or Town, State	, Zip Code)
Ž	12 ha 7 is		Joyce L. Phipps- 1	Daughter	917 8	Steprev R	load South	h. Abend	loon, Maryl	and 21001
e,	es 1 and of Healt fitem 2 r other		20a. Method of Disposition 1 Disposition 3 F	20b. P	Place of Dispo cemetery, crer	sition (Name of matory or other pla	ce)	Date	20c. Location - City	
Ĕ	Pag ment ient: i		'4 □ Donation 5 □ Other (Specify)	Be]		1em. Gard		and the second second second second	Bel Air, N	
Баппо	permit. Depart Import any in		21. Signature of Funeral Service Licens	egy.	22	Name and Address 1317 Cok			Funeral Ho ngdon, Mar	ome, P.A. Cyland 21009
	4.9	Г	23a. Pert1. Enter the disease, or comp shock, or heart failure. List only o	igations that caused the death	h. Do not ent	er the mode of dyii	ng, such as cardia	or respiratory ai	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Coromary	Art	EVV Dia	coace	with	Congestion	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	7 11-	11	1 +	Congestion	Years
	(A)	e.	Sequentially list conditions,	b. Due to (or as a conseq	uence of):			art to	ILURE	/
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		-					
Ď	be executed icien and burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):					
8/60	o ys	lical	(d						
OX PR	death certificate t e attending physis of for use as the b	an/Med	IF FEMALE:	23c. If yes, outcome of pregna	ancy				004 000 4	1
g	atten atten I for u	cian	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pregnanc Other (specify)	у		23d. Date of d Month	Day Year
j.	0 0 2	Physici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
ς, Τ	law requires that the de as been signed by the a 2 should be detached f	by P	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause gr	0 .			to the cause of death?
Records,	w require been sign		Chrome Ops	irrative	Juli	monary	y VISE	ase 101	Yes 2□No 3□	Pfobably 4 □Unknown
ě	e law has b	Completed	Chronic Fe	nal Insu	HICI	ency/		24a. Was autop		autopsy findings available o completion of cause of
a	sician: The law certificate has b irector, page 2 s							1 ☐ Yes	2□10 1□Y	es 2 No
Vital	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	t 3 DOA Ott		ath (Check only o	one) dence 6 □Other (Sp	necifu)
סו	g Physier this	T:U	27, Mann Death	28a. Date of Injury (Month, Day Year)	28b. Time of				how injury occurred	Josity
	r Attending Fler death. irector: After in by the funeral	atio	1 atural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,		Yes 2 No			
Division	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str y)	reet, factory, office		28f. Location (S City or Tox	Street and Number or wn, State)	Rural Route Number,
	spite hours meral y filled		29a. Certifier 1☐ Certifying Phy	sicien: To the best of my kno	owledge, death	h occurred at the ti	me, date and place	a, and due to the	cause(s) and manner	as stated.
	the Hi lin 24 the Fu	ledical	one)	iner: On the basis of examina and manner stated.	won and/or in					
	Vitt	Σ	29b. Signature and title of certifier	Ima -		29c. Licens	se number		29d. Date signed (Mo	ntn, Day, Year)
	111		30. Name and address of person who c	projected cause of death (last	n 23a) /Tune	Print)	19582	3	April 4	,2004
	, C		Make A . a M	7.4	. доц) (тура. Н Л	8 1	aw sti	reet	Aberde	er Maryland
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	/		1100)		
	Regist	rar	ADD 0 6 2004	Benefice 1	19 1	now that				

DHMH 17 Rev 1/2001

ORIGINAL

		4	For State Registrar			d / Depa		t of H	ealth a		ental Hyg	iene g. No. 20	04	10343
	Physicia		1. Decedent's Name (First, Middle, Last)		-						2. Date of Dear Month	h Day	Year	3. Time of Death
	/Medic	al -	Helen Louise Lucas 4a. Facility Name (If not institution, give s		aber)		4b. City.	Town, or	Location o	of Death	April 4	4c. County o	of Deeth	1:00 P M
	Examin	er	4402 Grandview Ave		,,,,,		,.		altim				N/A	
4	Funeral Director		5. Social Security Number 6. Sex		7. Age (In yrs. Id 7	as <i>t birthday)</i> 3 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Jan 10	Year) 1931		ece (State or Foreign ry) UCKY
	g		Usual Residence of Decedent		10c City	. Town or Lo	ontion						10	d. Inside City Limits
	anylar show	2	Maryland N/A		Toc. Oily	Balti								XiXiYes 2 ☐ No
	the M	Director	10e, Street and Number			Daiti	10f. Zip	Code			1	0g. Citizen of W	hat Count	ry?
	With With		4402 Grandview Ave	nue					212	11			Ī	JSA
	death	Funeral	11. Marital Status	2. Was Dece Armed For	dent Ever in U.S	S. 13.	Vas Deced	dent of Hi	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		- America	ın Indian,
920	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. If is marked other than "natural" or items 23a or 28a-f show traumatic avent, the Medical Examinant in notified at	b	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes If Yes, Giv Year or Da	3 √No e	1	1 □ Yes :		Specify:			Specify:		ite
215-0	hin 72 ho a. an "natu Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		-4or 5+)		kind of wor DO NOT us	rk done d se retir e d	turing mos)		ng	16b. Kind of Bus		
213	filed with Hygiene Sther tha	Com	12			Macl	nine S	Shop			(Fire Added)			ompany
Baltimore, Maryland 21215-0036	2 should be filed and Mental Hygie is marked other aumatic avent, it	To Be	17. Father's Name (First, Middle, Last) John Cotingame							Geo	rgia Sta	Maiden Sumame andiford	<u> </u>	
Mary	and 2 should salth and Men n 27 is marke		19a. Informant's Name/Relationship (Ty) Barbara Smyrnioudi				ng Address Martz				ille, M	c, City or Town, S aryland	State, Zip 217	
ore,	一工事芸		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	amoval from	20b. P	lace of Dispo emetery, crer	sition (Nari	ne of ther plac	9)			20c. Location - (-	
Ë	Pages ment of ant: If its ury or o	l	' 4 □Donation 5 □Other (Specify)		Woo	dlawn		-			/2004	Woodlawn	ı, Ma	ryland
Balt	permit. Pages Department of Important: If it any injury or once.	1	21. Signature of Funeral Service License	agent	4	E	631 I	e-Her	iss-Se	eitz	Raltimor	Home,	Inc.	
(c)			23a Part . Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Pinal	cations that called gause on e	aused the death	n. Do not ent	er the mod	le of dyin	g, such as	cardiac c	r respiratory arr	est,	1211	Approximate Interval Between Onset and Death
	Physician // Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):								4 gr
**************************************	Examiner	_i	Sequentially list conditions,	Spa to (or as a nonsult	uence of):								
	cuted nd ransit	Examiner	any, leading to annivolate cause. Enter Underlying Cause (Disease or injury that initiated events											
760,	te be executed ysician and e burial-transit	cai Ex	resulting in death) Last	Due to (or as a consequ	uence of):								
68	tificate ig phys as the	ledic												
O. Box	The law requires that the death certificate to has been signed by the attending physiste 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live b	come of pregna irth 2 ☐ Fetal ant at time of do own	death 3]Ectopic pi] Other (sp					23d. Date Mon	of delive	ry Day Year
0	uires that the de signed by the a Id be detached t	by	Part II. Dther significent conditions con	ntributing to de	eath but not res	ulting in the u	nderlying c	ause give	en in Part I		23e. Did to			e cause of death? abiy 4 □Unknown
of Vital Records,	The law requirate has been spage 2 should	Completed									24a. Was a autop perfor	med? d	rior to con eath?	sy findings available appletion of cause of
ital		BeC	25. Was case referred to medical examiner?							e of Death	Check on or	-		
) f V	d is	To E	1 Yes 2 No	-		ER/Outpaties	-		4 140			ence 6 □Othe)
	ding Ph h. After th funeral	lon:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	f M	28c. Injun Worl	yat k? Yes 2 □		28d. Describe h	ow injury occurre	ea De	
Division	or Attending Iter death. Virector: After n by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place buildi	of Injury - At ho ng, etc. (Specif	ome, farm, st y)					28f. Location (S City or Tow	treet and Numbe n, State)	er or Rurai	Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifying Phy (Check only 2 Medical Exemi	ner: On the b	best of my kno asis of examina ner stated.	wledge, deat	h occurred ivestigation	at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the ded at the time, d	ause(s) and mar late and place, a	nner as stand	ated. the cause(s)
	ithin 2 o the	Mec	29b. Signature and title of certifier	1	_		29	c. Licens	e number		1	29d. Date signed	(Month, I	Dey, Year)
	F ≯F 8		1 V 5h	2	011	2_		00	05	-6 à	39	Apper	e !	5,2004
-	7		30. Name and address of person who co	ompleted caus	se of death (Iten	п 23а) (Туре	Print)	0 E.	33rd	l Str	eet Bal	timore,	MD 2	
	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 6 2004	32. F	legistrar's Signa		loon							

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland				_	_		
		•	For State Of Maryland		ificate of L				14 1034	e le
		×	Decedent's Name (First, Middle, Last)				2. Date of Dea	ıth	3. Time of Dea	
	Physicia		CARRIE M. MILES				Month 04		0235	AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of	Death	
			RUXTON NURSING HOME		The state of the s	HLTIMDE	e e		NIA	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	Year)	9. Birthplace (State or Fo	oreign
ı.	Director		220 18 5073 1 M 200F 9	10 113.			03 19	1906	V /1	
	land ow	1		, Town or Loca					10d. Inside City L	imits
	Many a-f sh	to	MD NA	BALI	TIMORI	Ē			1 🕒 Yes 2 [□No
	or 28,	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of Wh	at Country?	
	hours after death with the Maryland lurel', or Items 23e or 28e-f show at Exercities must be notified at	rai	1627 Ruxton Avenue			1216		V	154	
	tems	Funerai	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	3. 13. Wa	as Decedent of Hi (es, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	- American Indian, White, etc.	
3	rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:	10	Yes 25 No	Specify:		Specify:	BLACK	
ş	72 hours after death with the Marylar "naturel", or Items 23a or 28a-1 show clical Exercities rosal ke notilised at		15. Decedent's Education	16a. Deceder	nt's Usual Occupa	ation		16b. Kind of Busi	ness/Industry	
212	hin 7.	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			furing most of work	ang			
7	filed within 72 Hygiene. Ither then "natent, the Madic	Completed	10th N/A	H0.1	NEMAK		=	Dome		
	a la b	Be	17. Father's Name (First, Middle, Last)			,		Maiden Sumame)	i	
<u>Ş</u>	should and Men s marke umatic	은	Edward 2055 19a. Informant's Name/Relationship (Type, Print)	10h Mailine	Address (Street	JNNO and Number or Rui			tata Zin Cada)	
Maryland 21215-0036	tra tra		Neison M. Miles	1627	_	A		. *	2 MD 212	11-
	s 1 and f Heall item 2 other		20a Method of Disposition 20b. Pla	lace of Disposit	tion (Name of		Date	20c. Location - C		14
ဋ	Pages nent of int: If it		1 108 Rurial 2 Cremation 3 Bemoval from State .		tory or other place		17/04	Randall	stown, M	D
Baltimore,	permit. Pages Department of Important: If I any injury or		21. Signature of Funeral Service Licenses			s of Facility				
ñ	De de la company		Danch C	SI	SI BALT	IMORE N	HTIONAL	PIKE, B4	LTIMOREMS.	2172
	3		23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.						Approximate Interval Betwee	en
	Physician		Immediate Cause (Final disease or condition END STAGE	OF RE	NA1.	DISEASE	-		Onset and Dear	,tn
	/Medical Examiner		resulting in death) Due to (or as a consequ					_		
. 9		16	Sequentially list conditions, if any, leading to immediate Due to (or as a consequ	uence of):						
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury							
o,	te be executed ysicien and te buriat-transit	Еха	that initiated events c	uence of):						
760	eath certificate be executed attending physicien and for use as the burial-transit	icai	d							
9	ntifica ng ph s as th	Physician/Med	IF FEMALE:							
Вох	ath ce ttendi or use	ian/	23b. Was decedent pregnant in the cast 12 months? 23c. If yes, outcome of pregnant 1 Live birth 2 Fetal	death 3 E	ctopic pregnancy			23d. Date Montl		ır
O	the a	ysic	1 Yes 2 No 9 Unknown	ath 5 □ C	Other (specify)				·	
<u> </u>	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	/Ph	Part II. Other significent conditions contributing to death but not resu	ulting in the und	lerlying cause give	en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death	h?
Vital Records,	uires n sign	d by					1 🗆 Y	'es 2 □ No 3	Probably 4 Unkr	nown
S	s beel	Completed					24a. Was	an 24b. We	ere autopsy findings avai	ulable
æ	The lav	E O					autop perfor 1 Tyes	med? de	or to completion of cause ath? Yes 2 No	9 01
ta	ian: rtifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Place of Dea				
<u>></u>	hysic his ce il dire	To	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient		4 Nursing H		ence 6 Other		
Division of	ing P		1 Natural 5 Pending (Month, Day Year)	28b. Time of Injury	28c. Injury Work	(?	28d. Describe h	ow injury occurred	ı	
Sic	death. death. ctor: A / the fu	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hor	ome farm stree		Yes 2□No	28f. Location (S	Street and Number	or Rural Route Number,	r.
<u>S</u>	or A	Certification:	4 Homicide determined building, etc. (Specify	")	n, rastory, smoo		City or Tow			,
	To the Hospital within 24 hours a To the Funeral completely filled		29a. Certifier 1 Certifying Physicien: To the best of my know							
	n 24 n 24 he Fu	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination and manner stated.	tion and/or inve	istigation, in my or	oinion, death occur	red at the time, o	date and place, an	d due to the cause(s)	
	To the Common Co	Σ	29b. Signature and title of certifier		29c. License			29d. Date signed ((Month, Day, Year)	
•	1		- Allrab fler		H48	543(MPRILI	,2004	
	N		30. Name and address of person who completed cause of death (Item	23a) (Type, Pr	rint)	A	o Post	Luiana	, 2004 MO 2120	3
	Sta	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signat	ture enut	Myno	MANN	1 200	were	NW CICO	-
	Regist		31. Date filed (Month, Day, Year) APR 0 6 2004	· Apres	(L)					
		100								

			1 - For State Registrar	State of Ma	ırylar	nd / Depa	artmen rtificat	t of H e of L	ealth a	ind M		Reg. No.			345
	Physici /Medio	al	1. Decedent's Name (First, Middle, L Mack James Mierr	nicki			15 65	T	I sastina -	4.0	2. Date of De.	02	, 200 ^{Year}	3. Time 6	
	Examir	ier	4a. Facility Name (If not institution, g 757 E. Fairview					rown, or napol	Location o	f Death			ne Arund	ല	
	Funeral Director				90 (In yrs.	last birthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Birl (Month, Da 12/17/	th	9. Birthp	place (State etry) ago,]	or Foreign
	faryland fahow ed al	ō	Usual Residence of Decedent 10a. State 10b. County MD Anne Ar	[obau		ty, Town or Lo	ocation				<u>. </u>		1	0d. Inside (City Limits
	with the h a or 28a-	Direct	10e. Street and Number 757 E. Fairview		AIIII	apolis	10f. Zip	Code 1403					izen of What Cour	ntry?	
36	d 2 should be filed within 72 hours after death with the Maryland th and Mantal Hygiene. It is marked other than "natural", or items 23e or 28e-f show traumatic event, the Medical Examination to indiffer a	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Amed Forces?				dent of Hi orfy Cuba	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)		14. Race - Americ Black, White, Specify: Whi	etc.	
215-00	nin 72 hou n "natura Wedical E	Completed	15. Decedent's (Specify only highest g		4)	16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	rk done a	urina most	of workin	ng	16b. Ki	ind of Business/In	dustry	
Maryland 21215-0036	e filed with al Hygiene other tha	Be Com	12 17. Father's Name (First, Middle, Las	1	*)	Maint	enand	ce Su	IPETVI		(First, Middle,		lding Ma Sumame)	nager	
ylar	ould be Mental narked c	ToB	Michael Miernic								ociluyk				
Mar	d 2 sh th and th and 17 is m traum		19a. Informant's Name/Relationship Hattie M. Mierni	* **									r Town, State, Zip , MD 214		
	os 1 and of Healt item 2 other		20a. Method of Disposition		20b. F	Place of Dispo					ate		ocation - City or To		
Baltimore,	nit. Page partment o fortant: If injury or		1 ☐ Burial 2 ☐XCremation 3 4 ☐ Donation 5 ☐ Other (Spec	cify)	1	tro Cre	emator	ˆу	4,	/5/04	1	Balt	imore, M	aryla	nd
Ball	permit. Pages 'Department of H Important: If ite any injury or ot		21. Signature of Funeral Server Lo	ensye).				s of Facility	Sta			eral Hom		Α.
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	vonecauseòn elach 🐃	e. Le p a consec per	(050 quence of):				4	-		(Asia	Approxima Interval Be Onset and	tween
68760,	icate be executed physician and sthe burial-transit	edical Examiner	cause. Enter Underlying Cause Dissessor in by that initiated events resulting in death) Last	c	conseq	quence of):									
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rds, P	signed be de		Part II. Other significant conditions Alzheimen		e My	-	nderlying c	ause give	n in Part I.	_		obacco u 'es 2[se contribute to th	e cause of	,
al Record	The law ate has b page 2 sl	Completed by											24b. Were auto prior to cor death? 1 Yes	npletion of a	
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ion of	ding h. After fune		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigati	28a. Date of Injur (Month, Day	y	28b. Time of Injury		8c. injury Work	at	2	8d. Describe h			7	
Division	or Diri	Certification:	3 Suicide 6 Could not determine		ry - At h	ome, farm, str fy)	eet, factory	, office		2	8f. Location (S City or Tow	itreet and m, State	d Number or Rura)	l Route Nun	nber,
	To the Hospital or All within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifying F (Check only one)	Physician: To the best of aminer: On the basis of and manner sta	examina	owledge, death ation and/or in	occurred vestigation,	at the tim in my op	e, date and inion, death	place, a	nd due to the o	ause(s)	and manner as st place, and due to	ated. the cause(s)
)	Tot Tot	Σ	29b. Signature and title of certifier	RI	\mathcal{D}^{ϵ}	2 pu		License		54			e signed (Month,	Day, Year)	
2	t i		30. Name and address of person wh	completed cause of de		n 23a) (Type,	Print)	, 71	5 X.	Fm	eric	R	310	35	
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 6 2004	32. Regist a	r's Signa	# 4	sout	21							

			For State Registrar	State of Maryl	and / Dep <i>Ce</i>	artment of F	lealth and <i>Death</i>		jiene _{leg. No.} 2	004	10346
	Physici		1. Decedent's Name (First, Middle, Last Beverly)		Mouz	on	2. Date of Dea Month	Day	Yeer 2004	3. Time of Death 22:51 PM
)	/Medio			ins Hospi	tal	Baltima	r Location of Dea	ty	N/A	ty of Death	Chate of Famina
	Funeral Director			х]м 2 X]F	7rs. last birthday, 44 Yrs.	Months Days	Hours Min		1959		ace (State or Foreign try) Land
	e Maryland 8a-f show diffind at	ctor	10a. State 10b. County Maryland N/A		city, Town or L Baltimor	e					0d. Inside City Limits 1
	th with the 23a or 2	Funeral Director	330 S. Dallas Cou	rt		10f. Zip Code 21231			10g. Citizen of USA	What Coun	try?
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be nutified at	by	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ XNo lif Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (S an, Mexican, Puel Specify:	Specify Yes or No- rto Rican, etc.)		ace - America ack, White, e	
Maryland 21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	(Give	edent's Usual Occup s kind of work done DO NOT use retire ployed	during most of wo		16b. Kind of	Business/Ind	lustry
yland 2	should be filed and Mental Hygic marked other	To Be Co	17. Father's Name (First, Middle, Last) Thomas Mouzon			-	Bessie	me (First, Middle,	Meiden Suma		
	1 and 2 s Health ar em 27 ls ther trau		Don Mouzon/Broth 20a. Method of Disposition	er	2704	ing Address (Street Norland osition (Name of ematory or other pla	Road E	Baltimore Date		21230	
Baltimore,	rtmer rtent: njury		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Few ra) Service License)	Metro Cr	ematory 1	Inc. 4-6		Baltim	ore, M	ID
Ä	perm Depa Impo any i		Edward A. G 23a. Part 1. Enter the disease, or compshock, or heart failure. List only of	recorchik Hotations that caused the course on each line.		2. Name and Addre Cremation 299 Frede liter the mode of dyi			Inc. imore,	MD 2	21228 Approximate Interval Between
68760,	Physician and // Medical Examiner the private and // Medical the // Medical the // Medical the // Medical the // Medical the //	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pneumonic Due to (or as a con Endocarc Due to (or as a con C. Due to (or as a con d.	sequence of):						Onset and Death 3 days 7 days
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pro 1 □ Live birth 2 □ i 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify)	у			ate of delive	ry Day Year
S	quires that on signed build be deta	by	Part II. Other significant conditions of Intravenous drug	•	resulting in the	underlying cause gr	ven in Part I.				e cause of death?
of Vital Record		Completed						24a. Was a autop perfor 1 Yes	sy	prior to con death?	osy findings available apletion of cause of
	ding Physician: Th h. After this certificate funeral director, pag	tion: To Be	27. Manner of Death 1 X Natural 5 Pending	Hospital: 1 M Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatre	of 28c. Inju	ner: 4 🗆 Nursing	eath (Check only of Home 5 Resid 28d. Describe h	ence 6 🗆 O)
Division	sel or Attending s after death. I Director: After ad in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - , building, etc. (Sp	At home, farm, si necify)	treet, factory, office		28f. Location (S City or Tow		iber or Rural	Route Number,
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in b	edical		ysician: To the best of my iner: On the basis of exar and manner stated.		nvestigation, in my	opinion, death occ				
)	To the within To the Comp	×	29b. Signature and title of certifier	Mb		29c. Licens	S-000	2	April	-	*
-	1		30. Name and address of person who of ERIC SCHMIDT JOHNS I	topkins Hospith	L 600 N	, Print) PRTH WOLF	E STREET	BALTIMORE	E MARYL	1NO 2	1287
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature.	books					

		For State Registrar	State of Mary				lealth a Death	nd M		eg. No.	200	3, Time of Death
Physicia /Medic		1. Decedent's Name (First, Middle, Last) $Helene \ E.$	Manning						APRIL	3,	2004	5:00 a
Examin		4a. Facility Name (If not institution, give s Spa Creek				Anna	polis					Arundel
Funeral Director		5. Social Security Number 6. Sex 573–18–6471	M 2 F 7. Age (In	yrs. last birthday 87 Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, AUG 3,	191	6 C	Birthplace (State or Foreig Country) anada
e Maryland Ba-fahow	Director	10a. State 10b. County Maryland Anne Ar		c. City, Town or L	An	napo]	lis			0- 04-		10d. Inside City Limit Yes 2 □ N
3 or 2	Dire	10e. Street and Number 84 Old Mill Botto	m Road		107. 2	ip Code	21401			-	en of What USA	Country
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other treumatic avant, the Medical Examinar count be multiped at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	in U.S. 13	. Was Dec If Yes, sp		lispanic Orig an, Mexican, Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		Black, W	merican Indian, hite, etc. White
within 72 hou ane. than "natura ne Wedical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Giv life.	edent's Us e kind of w DO NOT emake	rork done use retired	durina most	of working	ng		of Busine	ss/Industry
uld be filed wental Hygis Mental Hygis Irked other	To Be Co	17. Father's Name (First, Middle, Last) Julius Von Ferber					Unk		(First, Middle, I	Maiden S	iumame)	
d 2 sho th and N 7 is ma treuma		19a. Informant's Name/Relationship (Ty Joseph P. Manning/			ling Addre				n. NJ 0		Town, State	e, Zip Code)
permit. Pages 1 and 2 st Department of Health and mportant: If Itam 27 Is n any injury or other treun anges.		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	2	Ob. Place of Disposemetery, con Metro C	osition (N	ame of other plac	ce)	D	ate	20c. Loca		or Town, State
permit. F Departm Importar any injui		21. Signature of Funeral Service Licens Davin F. McDo	mald Omw	(d c	remat 99 Fr	ion S ederi	ss of Facility Societ Lck Ro	y of	Maryla Baltimo	nd, re,	Inc. MD 21	228
Physician /Medical Examiner pe priz	cal Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	iry	dit	cofe					Interval Between Onset and Death
death certific e attending pl of for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic		у			23	3d. Date of Month	delivery Day Year
uires that the de n signed by the a lid be detached f	b	Part II. Other significent conditions con	ntributing to death but no	ot resulting in the	underlying	cause giv	en in Part I.		23e. Did to	ابذ	р.	e to the cause of death? Probably 4 □Unknow
The law requires that the temperature the same signed by the page 2 should be detached.	Completed								24a. Was a autops perform	Sy	24b. Were prior death	
Physician: The l rthis certificate ha ral director, page	Be	25. Was case referred to medical examiner?	Hospital:			Ott		_	(Check only or			
문 된 필	. To	1 Yes 2 No	28a. Date of Injury (Month, Day Ye	2 ER/Outpati	of	28c. Injui Wo	4 (3-Nu		me 5 Residence 128d. Describe h			Specify)
ding Afte fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm,	М	1 🗆	rk? Yes 2∐I		28f. Location (S City or Tow		Number or	Rural Route Number,
To the Hospitel or Attendation 24 hours after deatl To the Funerel Director completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exemination	sician: To the best of miner: On the basis of example and manner stated	amination and/or	ath occurre investigati	ed at the ti	me, date an opinion, dea	d place, a	ed at the time, d	late and p	place, and	due to the cause(s)
To the within 2 To the complet	W	29b. Signature and title of certifier	MD			D 3	895	8		4/	5/0	onth, Day, Year)
St	ate	30. Name and address of person who con the control of the control	ompleted cause of death		e, Print)	60 lu	Road	1 #	#106	ODE	NTO	M M D 2111

			1 = For State Registrar		Marylar		artmen rtificate				lental Hy	Reg. No.	-20	04	103	348
	Physici /Medic Examin	al	Deedent's Name (First, Middle, Delphia Ann Mor Ann Escility Name (If not institution, §	ral	ber)		4b. City,	Town, or	Location		2. Date of De Month April	Day 1	200 County o		3. Time of 0	
F	uneral irector		2627 Georgetown 5. Social Security Number 212-56-8051		. Age (In yrs. 52	last birthday) Yrs.	If Under Months		timor If Under Hours		8. Date of Bi (Month, D OCT 2	rth av Year)		N/A 9. Birthpl Coun. Mary	ece (State or try) Land	Foreign
e Maryland	iffed at	ctor	Usual Residence of Decedent 10a. State 10b. County N/A		10c. Ci Ba	ty, Town or Lo	ocation e							10	0d. Inside City 1	-
n with the	3a or 28 at be no	ai Dire	10e. Street and Number 2627 Georgetown	Road			10f. Zip 21	Code 230				_	S.	hat Coun A •	try?	
filed within 72 hours after death with the Maryland	catains to recent and monthly goods. In the 23 a or 28e-f show injury or other traumatic event, the Medical Exercites must be notified at a	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tyes 1 If Yes, Give Year or Dat	es? No		Was Deced If Yes, spec	77	spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)	0-		- America k, White, a Wh		
nd 2 should be filed within 72 hours aft	r then "natur the Medical	ompleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-	4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done a	luring mos	t of work	ing	16b. Ki		siness/Ind	lustry	
ld be filed	ked othe	To Be C	17. Father's Name (First, Middle, La Melvin Morral	st)							e (First, Middle Harris		Sumame	9)		
nd 2 should	27 is mar r traumat		19a Informant's Name/Relationship Ronald Sitterly	(Type, Print) Son		19b. Maili 262	ng Address 7 Geo	(Street a	own F	er or Rura	Al Route Numb Baltim	ore,	r Town, S MD •	State, Zip 212		
permit. Pages 1 and 2	it: if item y or other	,	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe			Place of Disponentery, creation	matory`or o	ther place	9) 4	4-4 - 0	Date)4			City or To	wn, State	
permit. Pages 1 ar	Importan any injur once.		21. Signature of Funeral Service Li		Joset L						lome, I		11116	MD	2122	7
	sician ledical		23a. Part 1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	aty one cause on ea	ch line.	th. Do not en	ter the mod	e of dying	g, such as	cardiac	or respiratory a				Approximate Interval Betw Onset and Di	veen leath
te be executed	ysician and ne burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b	Coch	LK Y quence of):										
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uires that	E 2	by	Part II. Other significant condition	s contributing to dea	ath but not res	sulting in the u	inderlying c	ause give	en in Part I	٠			_/		e cause of de	
The law requires that the	ate has been si page 2 should I	Completed									24a. Was auto perfe 1 Yes	psy ormed?/	pr	rior to con eath?	osy findings a npletion of ca 2 No	vailable use of
Di Vital	certificate irector, pag	o Be	25. Was case referred to medical examiner?	Hospital:] ER/Outpatie		Othe			me 5 Res				,	
5 £	otor: After this the funeral di	-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Date of (Month		28b. Time o Injury		8c. Injury Work		1	28d. Describe					
LIVISION ital or Attending	within 24 nours ariel bear To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Place	of Injury - At h g, etc. <i>(Speci</i>	iome, farm, st	reet, factory	, office			28f. Location (City or To	(Street and wn, State)	d Numbe)	r or Rurai	Route Numb	<i>Ю</i> Γ,
Hospital	Funer Funer etety fill	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the la caminer: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred ivestigation	at the tim , in my op	ie, date an pinion, dea	nd place, ith occuri	and due to the ed at the time,	cause(s) date and	and man place, a	nner as sta nd due to	ated. the cause(s)	
To the	To the complete	Me	29b. Signature and title of certifier	rue m			290		number 5544	+13			-1	(Month, S	Day, Year)	
	18		30. Name and address of person w			m 23a) (Type,	Print) Han				altin				212	25
:	Sta Regist	ate rar	31. Date filed (Month, Day, Xear)	32/Re	gistrar's Sign		Low									

ORIGINAL

DHMH 17 Rev 1/2001

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		•	For State Registrar	State of	Marylan	id / Depa <i>Cei</i>	artment rtificate	t of H	ealth a Death	and M	ental Hy	giene No.2 (004	10349
	Physici	an	Decedent's Name (First, Middle, L SELM				MAIEF)			2. Date of De APRIL		/ Year	3. Time of Death 1:15 A M
	/Medic Examin		4a. Facility Name (If not institution, g		ber)				Location of	of Death	ALKIL	-	nty of Death	1.13 /
	LXaiiiii	Ci	LEVINDALE HEBREW	HOME				ГІМОІ	·-					N/A
	Funeral Director		5. Social Security Number 6. 219–30–4444	.Sex 7 1 □ M 2 ☑ F	7. Age (In yrs.	last birthday) 77 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da NOV . 7	^h 1 ^y 3 ² /6	9. Birth	olace (State or Foreign ontry) GERMANY
			Usual Residence of Decedent	<i>X</i>							1101.79	, 1520		GETATIVAT .
	ehow	7	10a. State 10b. County	TMODE	10c. Cit	y, Town or Lo		_						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Funeral Director	MD BALT 10e. Street and Number	IMORE		PIKE	10f. Zip				T	10g. Citizen o	of What Cou	
	th with	ai Di	3106 MARNAT ROA	\D					2120	8			1	U.S.A.
	iteme	uner	11. Marital Status	12. Was Deced	ces?	.S. 13.	Was Deced If Yes, spec	ent of His	spanic Orig n, Mexican	gin? (Spe i, Puerto	cify Yes or No Rican, etc.)	- 14. R	ace - Americ lack, White,	
920	72 hours after deeth with the Marylend naturel', or iteme 23a or 28e-f ehow jical Examinat must be natified at	by	1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	I Tyes : If Yes, Give Year or Da) ` `		1 ☐ Yes 2	No 🏋	Specify:			Spec	cify:	WHITE
2-0	72 hours "naturel", ulcal Ex.	Completed	15. Decedent's (Specify only highest g	Education grade completed)		(Give	dent's Usua kind of wor	k done di	uring most	t of worki	ng	16b. Kind of	Business/In	dustry
121	within ane. than	ldmo	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT US 1AKER	e retired)				OWN H	IOME	
d 2	Hygen than	Be Co	17. Father's Name (First, Middle, La	st)		HOHE	DVINEIN		18. Mothe	r's Name	(First, Middle,			
Maryland 21215-0036	should be and Mentai s marked o umatic eve	ToB	ISIDORE			MAIE	-			RENZ				WOLF
Mar	12 T T 12 T 10 T 10 T 10 T 10 T 10 T 10		19a. Informant's Name/Relationship KURT MAIER / BRO								I Route Numbe KESVILL			Code)
	1 an Heai em 2 ther		20a. Method of Disposition		20b. F	Place of Dispo					ate	20c. Location		own, State
E O			1 X Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec			EVRA Al				4/4/	2004	RAND	ALLST	OWN, MD
Baltimore,	permit, Page Department of Importent: If eny injury or		21. Signature of Funeral Service Lie	11500							LEVINS OAD - F			INC. MD 21208
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that ca ty one cause on ea a	used the death ich line.		er the mode			cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death On On This
	/Medical Examiner		and the second s	Due to (d	or as a conseq	uence of):								
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	s be executed sicien and burial-transit	Examine	cause (Disease or injury that initiated events resulting in death) Last	C	or as a conseq	uance of):								
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9	tificate t ng physic as the b	fedic		0.										
.O. Box	he death certificate be executed the attending physicien and ched for use as the buriat-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 ☐ Feta unt at time of d	Ideath 3□	Ectopic pre Other (spe						Date of delive Month	ery Day Year
٥.	iaw requires thet the de es been signed by the a 2 should be deteched	by Ph	Part II. Other significant conditions					use give	n in Part I.		23e. Did to	obacco use co	ntribute to t	he cause of death?
ords	w require been sig shouid b	ted to	HBP, Cereb	vovous	ular	disco	سےو				101	es 2 No	3 🔲 Prot	ably 4 Unknown
Vital Records,	The ate h page	Completed									24a. Was autop perfo 1 Yes	sy	prior to co death?	psy findings available mpletion of cause of
	Physicien: Th this certificate rai director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	patient 2	ER/Outpatier	* 30000	Othe			(Check only o	nfe)	ub (Ci)	
οľ	g Physical this neral di	-	27. Manner of Death	28a. Date of		28b. Time of Injury		Bc. Injury Work	at	7	ne 5 🗌 Resid 18d. Describe h			y)
sior	Attending I ir death, ector: After by the funer	catio	1 Alatural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	ion			М	1 🗆 Y	es 2 □!	1				
Division	i or Attence efter death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not determine	200. Flace	of Injury - At he g, etc. (Specif		eet, factory,	, office		2	28f. Location (5 City or Tox		nber or Rura	al Route Number,
_	Hospite 4 hours Funerel	edicai C	29a. Certifier Certifying I (Check only one) Medical Ex	Physician: To the laminer: On the barrand manner	sis of examina	wledge, death	occurred a vestigation,	at the time in my op	e, date and inion, deal	d place, a	and due to the o	cause(s) and r date and place	manner as s a, and due to	tated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and tyle of certifier	. 4			29c.	License	number			29d. Date sign	ned (Month,	Day, Year)
			Jun 11	1- degy	M		1	150	547	3		4/2/1	04	
	\		30. Name and address of person who				Levi	inde	abe					
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 6 2	100	egistrar's Signa	ture	ander							

			For State	State of M	aryland /	/ Depa		lealth and	d Mental Hy	giene 20	n L	10350
	Physici		1. Decedent's Name (First, Middle CANFORD	ə, Last)		n.	All IF	Dealin	2. Date of De	Rag. No.	Year 2Di-41	3. Time of Death
1	/Medio Examir		4a. Facility Name (If not institution NORTHWEST HOS			, ,		LSTOWN			y of Death	
· 产	Funeral Director		5. Social Security Number 220-07-4267	6. Sex 7. Ag	e (In yrs. last 81	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir	1922	9. Birthp Court	lace (State or Foreign http) MD
	Maryland f show	tor	Usuel Residence of Decedent 10a. State 10b. County MD B	ALTIMORE	10c. City, To		IMORE				1	0d. Inside City Limits 1 ☐ Yes 2 🏋 No
	with the a or 28a-	Direct	10e. Street and Number 3218 MAYFAIR				10f. Zip Code	21207	7	10g. Citizen of		ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marital Status 3 Never Married 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2	_		Vas Decedent of H Yes, specify Cuba		? (Specify Yes or No uerto Rican, etc.)		ce - Americ ack, White,	
Maryland 21215-0036	d within 72 ho giene. er than "natur . the Medical	Completed	15. Deceden (Specify only highe Elementary/Secondary (0·12) 12	t's Education st grade completed) College (1-4or		(Give lite. L	lent's Usual Occup kind of work done OO NOT use retired	during most of	working	16b. Kind of E		dustry
yland	should be file and Mental Hy marked oth umatic event	To Be (17. Father's Name (First, Middle, JOSEPH	JACOB		MILL		SAF				RUTH
	and 2 shi baith and n 27 is m	8	19a. Informant's Name/Relations JOANN MCLEAN		1		-		JE – BALT]	-		
Baltimore,	Pages 1 or nent of He int: If item		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 □Removal from State	ceme	etery, cren	sition (Name of natory or other plac JNAH (AIT		Date 1) 4/5/04	20c. Location BAL	- City or To	
Balti	permit. I Departm Importar any inju		21. Signature of Funeral Service	Trans.	•	22	. Name and Addre	ss of Facility	SOL LEVIN NN ROAD -	NSON & E	BROS.,	, INC.
760,	Physician /Medical Examiner of physician and bhysician and street private is the purial-transit	lical Examiner	23a. Part1. Enter the disease, by shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	a consequence a consequence	ce of):	heart	y Cu	Ime			Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetel dea	ath 3□	Ectopic pregnancy Other (specify)				ate of delive	ry Day Year
٥.	w requires that is been signed by should be detail	þ	Part II. Other significant condition	ons contributing to death b	out not resultin	g in the ur	iderlying cause giv	en in Part I.	23e. Did to	_/		e cause of death? ably 4 Unknown
Vital Records,		Completed									Were autor prior to cor death? 1 \(\sum Yes\)	osy findings available inpletion of cause of
f Vita	Physician: Th r this certificate ral director, paç	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 X No	Hospital:npati	ent 2 ER/	Outpatien	t 3□ DOA Oth	er	Death <i>(Check only o</i> g Home 5 ☐ Resk		her (Specify	·)
Division of	ling After fune	Certification: 7	27. Manner of Peath Natural 5 Pendir Accident investi	gation	ıry 28t y Yə <i>ar)</i>	b. Time of Injury	28c. Injun Worl M 1 🗀	yat k? Yes 2 □ No	28d. Describe I	now injury occur	rred	
D X	tal or Att rs after d al Direct ed in by t	Certifle	3 Suicide 6 Could 4 Homicide determ	ined 200. Place of In	ury - At home c. (Specify)	, farm, stre	eet, factory, office	ower La	28f. Location (S City or Tov		ber or Rura	Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	Medical	29a Certifier (Check only one) Certifyii Medical	ng Physician: To the best Examiner: On the basis of and manner st	f examination	dge, death and/or inv	occurred at the tin restigation, in my o	ne, date and pla pinion, death o	ace, and due to the courred at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
)	To t To t	Σ	29b. Signature and title of certifie	h/	^		29c. Licens	e number 3,977		29d. Date signe		
	15		30. me an add ess o erson	who completed cause of o	deat Wem 23	a) ype	DRAR.	Colon 1	3mil		210	2004 ld
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 6	2004 33 Registr	ar's Signature	100	e de la companya della companya dell					

			For State Registrar	State	of Mary	land / Dep <i>Ce</i>	artment o	of Health of Death	and Me		ene 2 0	04	10351
	ý		1. Decedent's Name (First, Middle	, Last)	-				2	2. Date of Death Month	Day	V	3. Time of Death
	Physici /Medio		FRANCES				MYEI	RS	Α	PRIL		Year 2004	6:14 AM
Н	Examin		4a. Facility Name (If not institution	, give street and	f number)		4b. City, Tov	vn, or Location	of Death		4c. County	of Deeth	1
			HARBOR HOS	PITAL	CENT	ER	BAL	LTIMOR	RE				
	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday		ear If Under ays Hours	Min.	B. Date of Birth	Year)	9. Birthp	place (State or Foreign
ı.	Director		213-20-5491	1□M 2및	F 78	Yrs.	WORKIS	ays	IVIII.	B. Date of Birth (Month, Day, 10/21/	1925		yland
Т	Б .		Usual Residence of Decedent		100	c. City, Town or L							
	aryla shov	_	10a. State 10b. County		100	c. City, Town or L	ocation					1	Od. Inside City Limits 1√2 Yes 2 □ No
	Ba-f	ctc	Maryland			Baltimo							
	vith ti	ä	10e. Street and Number				10f. Zip Co			10	g. Citizen of		•
	ath v	Funeral Director	236 South East				212					ed St	
	ltam:	nue	11. Marital Status	Arme	Decedent Ever d Forces?	in U.S. 13.	Was Decedent If Yes, specify	of Hispanic Or Cuban, Mexica	rigin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)		ce - Americ ck, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☑ Divorced	If Yes	es 2 No , Give X or Dates:		1 ☐ Yes 2 ∑	No Specify.	:		Specif	y Whi	.te
8	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f show its Madical Exanti in trial Le notified at	edt	15. Deceden		or Dates.	16a Dece	dent's Usual O	ccupation		1	6b. Kind of B		
5	in 72	Completed	(Specify only highes	t grade complet		(Give	kind of work di DO NOT use re	one during mos	st of working	'	ob. Mild of b	Jan 1033/11 N	203ti y
7	with lene.	ma	Elementary/Secondary (0-12)	Collec	ge (1-4or 5+)	Packe	er				Meat Fa	actor	v
g	Hygier other th	Bec	17. Father's Name (First, Middle,	Last)				18. Moth	er's Name (First, Middle, M			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23e or 28e-1 show other traumatic event, the Mardical Examiner man be notified at	To B	John Rachuba					Hel	en S	obus			
37	shou nd M mar	_	19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address (St	reet and Numb	er or Rural I	Route Number,	City or Town,	State, Zip	Code)
	nd 2 alth a 27 is		John E. Cituk S	srSon		236	South 1	East Av	enue,	Baltim	ore, M	aryla	nd 21224
ē,	s 1 a f Hei fram fram othe		20a. Method of Disposition	-	2	0b. Place of Disponentery, cre	osition (Name o	of place)	Dat	te 2	0c. Location -	City or To	wn, State
Ë	Pages nent of nnt: If It		1 Donation 5 Other (S		OIII State	St. Stan:			v 4/7	/04 B	altimo	re. M	arvland
altimore,	그 든 뿐 등	. 10	21. Signature of Funeral Service			1 2	2. Name and A	ddress of Facili	ity	_			
m	permi Depa Impo any ir		► Kn+hloox	All	Johon	('FSHR	ayid J	Weber	Funera	al Home	S. P.A	Marri	land 21231
400		v :	23a. Part1. Enter the disease, or	complications th	at caused the	death. Do not en	ter the mode of	dying, such as	cardiac or r	espiratory arre	st,	магу	Approximate
940	Dhysisian		shock, or heart failure. List Immediate Cause (Final	·				0					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)			OBSTRU	CTIVE	PULINO	MARY	1214	FAJE		20 YRS
	Examiner				ONGES		HEAR.	T GA	11110	£			4 YRS
) i	er	Sequentially list conditions, if any, leading to immediate	b. Due	to (or as a co	nsequence of):	1100110	17	TUCK	t			. 710
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	f . f	NEUM	ONIA							10 DAYS
ó	te be executed ysicien and ie burial-transit		resulting in death) Last	Due	to (or as a cor	nsequence of):							
760,	ate be executed hysicien and the burial-transit	cal		d									
89	tifica ng ph as th	fed											
P.O. Box	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		outcome of pr		DEctopic pregna	ancy			23d. Dai	te of delive	,
m m	deat	SICIE	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 P	regnant at time		Other (specif)				Мо	nth	Day Year
o.	by the	hys	9 🗆 Unknown							1			
ŝ	The law requires that the death certifica Ite has been signed by the attending ph tage 2 should be detached for use as the	by F	Part II. Other significent condition				nderlying cause	e given in Part I	l.	23e. Did toba	icco use cont	ribute to th	e cause of death?
בַ	en si ould		ATRIAL	FIBRILL	LATION	J				₹. Yes	2 🗆 No	3 Proba	ably 4 □Unknown
ပ္ထ	as be	Completed								24a. Was an autopsy	24b. \	Were autor	psy findings available impletion of cause of
ř	Physician: The lav this certificate has ral director, page 2	ШО								perform	ed? c	death?	2D No
ta	rtifica	Be C	25. Was case referred to medical	1				26. Place	e of Death (Check on one			22110
>	ysic is ce direc	ToE	examiner? 1 ☐ Yes 2:☑No	Hospital:	Inpatient	2 ER/Outpatie	nt 3 DOA	Other: 4 No	ursing Home	5 Residen	ce 6 Oth	er (Specify	()
Division of Vital Records,	ding Ph h. After th funeral		27. Manner of Death	28a. D	ate of Injury Month, Day Yea	28b. Time o	28c. l	Injury at Work?		d. Describe how			,
O .	ath. ath. or: Af	atlc	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	ation		,,		1 Yes 2	No				
<u> </u>	r Attencer death rector: by the	tific	3 Suicide 6 Could r	ned 289. F	lace of Injury - uilding, etc. (S)	At home, farm, st	eet, factory, off	ice	281	Location (Stre	et and Numb State)	er or Rural	l Route Number,
	rs aft al Di	Certification:			J						,		
	non i		29a. Certifier (Check only 2 Medicel	g Physicien: To	the best of my	knowledge, deat mination and/or in	h occurred at th	ne time, date an	nd place, and	d due to the cau	ise(s) and ma	nner as str	ated.
	To the Hospital or Atlanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical	one)	and n	nanner stated.	The second secon							
	To To	2	29b. Signature and title of certifier					ense number			d. Date signed		•
	,		Wavelet M	uja	M. 1	٥.	P	1598	2.		April	4/2	004
	X		30. Name and address of person	who completed o			Print)						- 212as.
	1.		NAVNEET AHU		3001	S. HANG	OVER .	STREE	()	BALTIM	ORE	, ms	- 21225.
	Sta		31. Date filed (Month, Day, Year)	,0	2. Registrar's S	Signature							
	Registr	ar	APR 0 6 2	004	Deal s	IF Aco	A 30 1						

			r ic	Chata at Maral				_	
			For State	State of Maryla	and / Department o			-200L	10050
			1 - State Registrar		Certificate of	of Death	Reg. N	10.2004	10352
	Physici	an	1. Decedent's Name (First, Mic		SPAUGH			year)	3. Time of Death
	/Medic	al	4a. Fecility Name (If not institu			m, or Location of Death	APRIL 2	4c. County of Death	1,30.1
	Examir	ier	GILCIDIS	ST OFNITER	TOL	25001	1	2AI TIM	NORF.
L-	Funeral		5. Social Security Number	6. Sex 7. Age (In y	rs. last birthday) If Under 1 Y		8. Date of Birth	9. Birthp	lace (State or Foreign
100	Director		215-24-1797	1/2M 2□F	73 Yrs. Months Da	ays Hours Min.	JULY 27,1	930 OH	
	p ,		Usual Residence of Decedent 10a. State 10b. Cour		City, Town or Location				Od Incide City Limite
	show	5	10a. State 10b. Cool	ITIMONT (2112TOLL			l'	0d. Inside City Limits 1 ☐ Yes 2 No
	28a-f	Director	10e. Street and Number	CHINORE	10f. Zip Coo	de .	100.0	Citizen of What Coun	
	with with the control		15 PIXI	EA CIT.	2)	MIL	1)	LITED	STATES
	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in	n U.S. 13. Was Decedent	of Hispanic Origin? (Spi Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
9	or Ite	Ē	1 Never Married 2X N	Armed Forces? 1 Yes 2 □ No If Yes, Give	1 ☐ Yes 2	,	Hican, etc.)	Black, White,	etc.
03	within 72 hours after death with the Maryland one. one. than "natural", or items 23a or 28a-f show item "Medical Evertiral relations and the notified at	d by	3 ☐ Widowed 4 ☐ Divorce	ced Year or Dates: 48-	.58			Specify. V	1110
7	natu alica	Completed	15. Dece (Specify only hig	dent's Education ghest grade completed)	16a. Decedent's Usual Od (Give kind of work do life. DO NOT use re	one during most of work	ing 16b.	Kind of Business/Ind	dustry
12.	withir ene. then	E G	Elementary/Secondary (0-12	2) College (1-4or 5+)	PRESIDE	= 1	5	LVERCO	napaniv
2	be filed ital Hygi d other	Be Co	17. Father's Name (First, Midd	dle, Last)	1100100		e (First, Middle, Maide	en Sumame)	111.01
<u></u>	Mental Rental Red ic ev	To B	MARTINI LA	AURENCE A	MILLSPAUGI	H ELIT	ARFITH	PARK	<
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. It has the marked other than "natural", or Items 23e or 28e-1 show other traumatic event, Ita Medical Examinar must be notified at	Γ.	19a. Informant's Name/Relation		19b. Mailing Address (St.	reet and Number or Run	al Route Number, City	or Town, State, Zip	Code)
2	and 2 ealth a m 27 is		ELEANOR N	11USPAUGH/W	TE 15 RUXLE	ACT., RUX	XTON, M	10 2120	DY
o.	ges 1 If it it		20a. Method of Disposition 1 □ Burial 2 □ Crematic	on 3 Removal from State	 Place of Disposition (Name of cemetery, crematory or other 	place	Date 20c.	Location - City or To	wn, State
<u>.</u>	mit. Pages vartment of l oortent: If its injury or o		*4 Oonation 5 □ Other	r (Specify)		rs KEG 04/	0404 14	MOVER	2, MD
Baltimore	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr		21. Signature Europe Serv	Licensee		erty Family Funeral He			
-	1 102 4 4		237 Part 1 Fater the disease	o complications that		601 Mountain Road		21122	Approximate
			shock, or heart failure. I	o, or complications that caused the d List only one cause on each line.					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a5		Concer	<		year
3	Examiner			Due to (or as a con	sequence or).				U.
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Universe of highly that initiated events	b. Due to (or as a con	sequence of):				
3	cuted	Examiner	cause. Enter Underlying Cause (Disease of Injury) that initiated events	1 c					
50	be executed ician and burial-transit		resulting in death) Last	Due to (or as a con	sequence of):				
0 3760	eath certificate be execu attending physician and for use as the burial-tra	lical		d,					
70 89	certificat	Mec	IF FEMALE:	20. 11					
4	death or	lan/	23b. Was decedent pregnant in the past 12 months?	I LICIVO DIREIT Z L	Fetal death 3 ☐ Ectopic pregn			23d. Date of delive Month	ory Day Year
	the de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5 Other (specify	y)			
8)0	w requires that the death certificate been signed by the attending phys should be detached for use as the	by Physician/Medi	Part II. Other significant cond	ditions contributing to death but not	resulting in the underlying cause	e given in Part I.	23e. Did tobacco	use contribute to th	ne cause of death?
2 %	requires een sign						1 🗆 Yes	2 No 3 Prob	ably 4 Unknown
<u>,</u> } 5	w req	lete					24a. Was an	24b. Were autor	psy findings available inpletion of cause of
8 8	The lav	Completed					autopsy performed? 1 ☐ Yes 2 ☑ N	death?	
100	vicien: Th certificate rector, pag	0	25. Was case referred to med	dical		26. Place of Deatl	1 ☐ Yes 2 X N h (Check only one)	10 10193	20110
_5.3	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient 3 DOA	Other: 4 Nursing Ho	me 5 Residence	6 Other (Specif)	1) (+ OSPICE
9	ding Ph th. : After th		27. Manner of Death 1 X Natural 5 ☐ Per	28a. Date of Injury (Month, Day Yea	28b. Time of 28c.	Injury at Work?	28d. Describe how in	ury occurred	
3	tendi leath. tor: A	catl	2 Accident Inve	estigation		1 ☐ Yes 2 ☐ No			
	l or Attendate death Director:	Certification:		termined 28e. Place of Injury - A building, etc. (Sp	At home, farm, street, factory, off ecify)	fice	28f. Location (Street : City or Town, Sta	and Number or Rura. ite)	l Route Number,
700	spitel ours a lerel (29a. Certifier 1 🔀 Certi	ifying Physician: To the best of my	knowledge, death occurred at th	ne time, date and place.	and due to the cause	(s) and manner as st	ated
MIN S	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medi	ical Examiner: On the basis of exam and manner stated.	nination and/or investigation, in r	my opinion, death occurr	red at the time, date a	nd place, and due to	the cause(s)
~	To th within To th	Me	29b. Signature and title of cer	rtifier /	29c. Li	cense number	29d. D	Date signed (Month, I	Day, Year)
	,		I M for	thony Kiley	, mo De	25205	Ax	wil2,0	2014
_	'n		30. Name and address of pers	son who completed caus of eath (Item 23a) (Type, Print)	. P. SL .	2 00 111	1 212	n &
			W.A-Ril	ey GBMC	0101 1x. Cu	AUS J. F.	ant. mi	100	·/`
	Sta Regist	ate rar	31. Date filed (Month, Day, Ye APR 0 6 200)	early 32. Registral s 3	S Apas Mal				
	riegist	rei	APR V U ZUU	4 22	John Cook				

DI		1. Decedent's Name (First, Middle, La	ist)	- Jeann	e McK	Kenna				2. Date of De Month	path Day /	Yeer /	3. Time of Death
Physici /Medio		McKen	19,1	ear	me	ســـــــــــــــــــــــــــــــــــــ				3	14	04	(0:2) H
Examin	er	4a. Fecility Neme of not institution, gir	H1 (1	100	0/		8	Location of	90	, Me		Inty of Deeth	elbot
Funeral Director		,	Sex 7.Ag 1□M 2∏2F	90 (In yrs. la:	st birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Jan 19	in y, Year) 1927	Col	nplace (State or Foreig untry) 'York
		Usual Residence of Decedent		40.00	T	- 27.5							
f show	lor	MD Talbo	t		Town or Locaston	cation							10d. Inside City Limit: 1 ☐ Yes 27 No
r 28a	Irec	10e. Street and Number		J		10f. Zip	Code				10g. Citizen	of What Cou	untry?
23a	raiD	501 Dutchman's L						1601				USA	
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avant, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 22 If Yes, Give Year or Dates:	Ever in U.S No			dent of Hi ecify Cuba 21 No		gin? (Spec i, Puerto R	cify Yes or No lican, etc.)		Race - Amer Black, White ecify: W	
natura dical E	eted	15. Decedent's E (Specify only highest gi			16a. Deced	kind of wo	ork done a	uring most	t of workin	g	16b. Kind o	of Business/I	ndustry unl
than T	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. D	OO NOT u	ise retired, Loye)					
arked other atic avant, t	BeC	17. Father's Name (First, Middle, Las				•		18. Mothe			. Maiden Sun		
s marked umatic av	2	Herbert Charl			40h 44-15-		- /5				ngoech		in Code)
27 is n traun		19a. Informant's Name/Relationship Mary E. McKenna				-					er, City or To ak, MD		(p C306)
		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from State	COL	ce of Dispos metery, crem	sition (Na	me of			ate		on - City or 1	Fown, State
Important: I any injury o once.		21. Signeture of Funeral Serve a Lice RONA I. S.	Wade Wa	ector	St	ate A	nd Addres Anato ore,		y Dard 21201	655 W.	Balti	more S	Street
ysician Medical		23a. Part Enter the disease, of cor shock or heart failure. List only Immediate Gause (Final disease or condition resulting in death)	one causs on each li	ine. Lin:	50r	er the mod	de of dying	such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
aminer			b. Due to (or as	a conseque	ence of):								years
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Clula to (or dis	a conseque	ande of):								J ,
hysicien and the burial-transit	Ical Exar	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):								
attending phy	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic p	reonancy				23d.	Date of delir	,
ed by the att	ysicia	in the past 12 mooths? 1 □ Yes 2 Ø No 9 □ Unknown	4□Pregnant a 9□Unknown			Other (s)						Month	Day Year
D 90	by	Part II. Other significant conditions	contributing to death b	out not result	ting in the un	nderlying (cause give	n in Part I.			tobacco use d		the cause of death?
has been sign 2 should	Completed	Hypohi	roid							24a. Was	psy	b. Were au	opsy findings available
ate	Соп									perfo	ormed? 2 □ No	death?	2 No
certif	o Be	25. Was case referred to more examiner?	Hospital:		R/Outpatien		Othe Othe	er .	/	(Check only	titler on	Other (Core	
er this seral di	-	27. Mann of Death	28a. Date of Inju	ury 2	28b. Time of Injury		28c. Injury Work				dence 6 D		ny)
ੂ ਵੇਂ ਡੋਂ	catio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	on			М	1 🗆 '	/es 2 □ I		 	_		
	Certification:	3 Suicide 6 Could not 4 Homicide	28e. Place of in	jury - At hon tc. <i>(Specify)</i>		eet, factor	y, office		21	8f. Location (City or To		umber or Ru	ral Route Number,
within 24 hours after To the Funeral Dire completely filled in b	edical		hysician: To the best miner: On the basis of and manner st	of examination									
rithin Fo the comple	Me	29b. Signature and title of certifier				29	c. License	number		,	29d. Date sig	gned (Month	Day, Year)
		> Valled				1)00	53	191	1	31	115	104
		[[/_P U] #P											

ORIGINAL

		•	For State Registrar	State of Maryland		artment of F		-	giene Reg. No. 20	04	10354
	Physici /Medic	_	Decedent's Name (First, Middle, Last)	Evelyn M.	Ort	nyer		2. Date of De Month	ath	2 004	3. Time of Death
	Examin		4a. Facility Name (If not institution, give str	are Hospi	tal	4b. City, Town, o	e do	2	Bo	1+10	nore
	Funeral Director		5. Social Security Number 215-12-8617 Usual Residence of Decedent	7. Age (In yrs. h		Months Days	Hours Min.	8. Date of Bir (Month, Da Dec. 8	1922	Mary	ace (State or Foreign try) Land
1215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23e or 28e-f show eny injury or other treumatic event, I've Medical Evantiner must be notified at anone.	tor	10a. State 10b. County MD Baltimo:	-	, Town or Lo Ess					10	0d. Inside City Limits 1 ☐ Yes 2 🛣No
		ai Director	10e. Street and Number 2236 Monocacy I	Road	10f. Zip Code 2122	10f. Zip Code 21221			10g. Citizen of What Country? USA		
		by Funeral	11. Marital Status 12 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🕱 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Bla	ce - America ck, White, e yWhit	etc.
		Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) 12th	tion completed) College (1-4or 5+)	(Give life. l	tent's Usual Occup kind of work done DO NOT use retired	pation during most of work d)	king	16b. Kind of B		,
Naryland 2121	uld be filed Mental Hygi arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) John L. Hamma	n			18. Mother's Nam Bertha			ne)	
	ages 1 and 2 sho nt of Health and I : If item 27 Is ma : or other treums		19a. Informant's Name/Relationship (Type Richard Ortmyer 20a. Method of Disposition 1 Burial Method 3 Rel	/ husband	223	-	ce) .		-	MD - City or Tor	wn, State
Evely Baltimore,	permit. Pa Departmer Important eny injury		. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee			. Name and Addre	as of Facility	onnell	yFuner	alHon	neofEssex
3760,	/Medical Examiner // // // // // // // // // // // // //	dicai Examiner	23a. Part 1. Enter the disease, or complications, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence to (or a))).	uence of):	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Box 6	requires that the death certific neen signed by the attending p hould be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	,			ite of deliver	ry Day Year
Division of Vital Records, P.O.	w requires that the been signed by should be deta	Completed by Ph	Part II. Dther significant conditions control ACUTE Renol	ven in Part I.	23e. Did tobacco use contribute to the cause of dea		ably 4 Unknown				
al Rec	The larate has							1 Yes	rmed? 2 No	Were autop prior to com death? 1 Yes	osy findings available inpletion of cause of
of Vit	Physician: rr this certifica aral director, prai	: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	spital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien		4 Nursing no	ome 5 Resid	dence 6 Oth)
ivision	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At ho building, etc. (Specify	Injury ome, farm, str	M 1 🗆	rk? Yes 2 □ No	28f. Location (S City or Tov	Street and Numb vn, State)	per or Rural	Route Number,
۵	Hospitel (24 hours ai Funeral D	Medical Ce		cian: To the best of my known: On the basis of examinat and manner stated.							
	To the within / To the comple	Me	29b. Signature and title of certifier	N	,	29c. Licens	7 2 5 5		29d. Date signe		1.1
	4		30. Name and address of person who com Dr. James Mcgove	pleted cause of death (Item 1000 F (o	23a) (Type,	Print)	repriv	e Bal	timor-	e, M	D 2/237
	Sta Regist		31. Date filed (Month, Day, Yeat) APR 0 6 2004	32. Registrar's Signal	ture /	parks				-/-	

			1 State Registrar	tate of Maryland /			lealth and	P	jiene •g. No. 2	004	
	Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last) Ge 4a. Facility Name (If not institution, give street)	erald Robert	0'N	eill 4b. City, Town, or	r Location of De		Day 26, 20		3. Time of Death 9:00 P.M
	Funeral	iei	1535 Clairidge Road 5. Social Security Number 6. Sex. 1124M	7. Age (In yrs. last b	irthday) Yrs.	Balti If Under 1 Year Months Days	more		Balt	imore	ace (State or Foreign try)
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Ind other than "natural", or tems 23a or 28a-f show event, I'm Medical Examer must be multipled at	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Milloworced 15. Decedent's Educatic (Specify only highest grade coll Elementary/Secondary (0-12)	Was Decedent Ever in U.S. Armed Forces? I ØYes 2 □ No if Yes, Give Year or Dates: Koren on photod College (1-4or 5+)	13. 1	10f. Zip Code 21207 Was Decedent of Hif Yes, specify Cuba 1 Yes, 2 X No dent's Usual Occupy kind of work done coo NOT use refired	ispanic Origin? in, Mexican, Pu Specify: ation during most of w	(Specify Yes or Noerto Rican, etc.)	0g. Citizen of V U · S · 14. Race Blac	Vhat Count A. 9 - America k, White, e	od. Inside City Limits 1 Yes 2 No iry? an Indian, te
Maryland 21	be filed ntal Hygi nd other event, I	To Be Col	12 17. Father's Name (First, Middle, Last) Robert O'Neill 19a. Informant's Name/Relationship (Type, I			onditione	18. Mother's N Elizab	ame (First, Middle, F eth Hagen	c	в)	
Baltimore,	Example Dermit. Pages 1 and 2 Department of Health a My mourtant: if item 27 is any injury or other trai	her	Steven M. O'Neill 20a. Method of Disposition 1 Burial 2 Cremation 3 Remo 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	(Son) 2 oval from State 20b. Place comete Wood1	90 (of Dispo	Campbell I sition (Name of natory or other place Cemetery . Name and Address 228 Libert	Mill Ro 04/ s of Facility L	05/04 Voring Byen	New Ha	ampsh City or Tow A. Mar Cal D: D. 21	ire 03048 wm,State ryland irectors I
c 68760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Medical Examine	resulting in death) Last	Due to (or as a consequence	Le	nsion	d~	riore			5 yrs
O. Box	at the death certific by the attending p tached for use as i	Physician/Med	23b. Was decedent pregnant in the past 12 months?	f yes, outcome of pregnancy □ Live birth 2 □ Fetal death □ Pregnant at time of death □ Unknown		Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th D	/ Day Year
ecords, P	w requires that been signed b should be det	þ	Part II. Dther significant conditions contribu	iting to death but not resulting	in the un	derlying cause give	n in Part I.	23e. Did tob			cause of death?
r		e Completed	25. Was case referred to medical				00 Fl. (0	24a. Was ar autopsy perform 1 Yes 2	ed? de	ere autops ior to comp ath? Yes 2	sy findings available pletion of cause of
IVISION OF	or Attending Phy ter death. irector: After this by the funeral d	Certification: To B	examiner? 1 Yes 2 100 Hospid 27. Manner of Death 1 Natural 5 Pending investigation	3a. Date of Injury 28b.	Time of Injury		r: 4 Nursing	Path Check only one Home 5 series del 28d. Describe hor 28f. Location (Str. City or Town,	nce 6 □Other vinjury occurre eet and Number	d	Route Number,
	To the Hospital of within 24 hours af To the Funerel D completely filled in	Medical C	one)	n: To the best of my knowledge On the basis of examination ar and manner stated.	e, death nd/or inv	estigation, in my opi	inion, death occ	curred at the time, da	te and place, ar	nd due to th	ne cause(s)
	\(\rho\) \(-	29b. Signature and little of certifier 30. Name and address of person who comple	po cause of death (tem 23a)	(Type, F	29c. License	2 9 7	69	d. Date signed	(Month, De	y, Year) 04 30. (La
4	Sta Registr		31. Date filed (Morth, Day, Year)	32. Begistrar's Signature	ml	land of	5/6	M. Roll	ving Rel	n	12/20

			1- For State of N	laryland / Depa Cei	artment of Heal	lth and Me		iene 99. No. 2004	10356	
		in	Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death	
	Physici /Medi		Fay Oppermann				Month April	Day Year 3 • 2004	9:00 AM	
	Examir		4a. Facility Name (If not institution, give street and number	r)	4b. City, Town, or Loca		<u></u>	4c. County of Death		
			5466 Phelps Luck Drive 5. Social Security Number 6. Sex 7. A		Columbia			Howard		
	Funeral		1□M 2DTE	ge (In yrs. last birthday) 88 Yrs.		Jnder 24 Hrs. g ours Min.	B. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)	
	Director		071-14-7737 Usual Residence of Decedent	88 Yrs.		J	une 2	, 1915 Ne	w York	
	/land		10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits	
	Mar a-f sh	ģ	MD Howard	Columbia					1 ☐ Yes 21 No	
	th the	le	10e. Street and Number		10f. Zip Code		10	Og. Citizen of What Cou	intry?	
	within 72 hours after death with the Maryland ane, than "natural", or Items 23a or 28a-f show he fiscal Examinar must be notified at	Funeral Director	5466 Phelps Luck Drive		21045			USA		
	tems	nuel	11. Marital Status 12. Was Deceden Armed Forces	?	Was Decedent of Hispan f Yes, specify Cuban, Me	nic Origin? (Speci exican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White		
36	s afte	by Fi	1 Never Married 2 Married 1 Yes X If Yes, Give Year or Dates]No	_	ecify:			white	
21215-0036	tural	ed	3X Widowed 4 Divorced Year or Dates 15. Decedent's Education		dent's Usual Occupation			16b. Kind of Business/li		
215	nin 72 n "na Merik	plet	(Specify only highest grade completed)	(Give	kind of work done during DO NOT use retired)	g most of working		TOD. KING OF BUSINESS/II	loustry	
212	d with	Completed	Elementary/Secondary (0-12) College (1-4or	Teacher	~		9	School Sy	stom	
b	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic evant, the Medical Examinar must be notified at	Bec	17. Father's Name (First, Middle, Last)			Mother's Name (i	First, Middle, N	faiden Sumame)	3-Cem	
yla	should be fand Mental Hand Mental Handwarkad of umatic eva		Ivan Agard	·	I	indsey	Норро	ough		
Maryland	s 1 and 2 should f Health and Men itam 27 Is marka othar traumatic		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and N					
	1 and 2 Health tam 27		Brad Oppermann/son		Longlook		-			
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cren	sition (Name of natory or other place)	04/07		20c. Location - City or T	own, State	
ţ					sh.Cremat	corv	I	aurel, M	5	
Ba	permit. Departr Imports any inju		21. Signature of Funeral Service Lisensee	22	. Name and Address of F	Facility Witz	ke Fur	neralHome:	s, Inc.	
	•		23a. Part1. Enter the disease, or complications that cause	the death. Do not ent	055 TWIN K	nolls	Road,	Columbia	Md.21045	
			shock, or heart failure. List only one cause on each	line.					Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	t (an crr	ms tas tati	c to lo	13 ang	Part	14 x ms.	
п	Examiner			s a consequence or):						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	s a consequence of):		·				
	cuted nd ransit	Examiner	that initiated events							
oʻ	e exe ian a urial-t		resulting in death) Last Due to (or as	s a consequence of):						
8760,	The law requires that the death certificate be executed at the has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	dlcal	d		-					
9	eath certific attending p for use as	/Mec	IF FEMALE:	,			-X-44-7			
Box	ath c attenc for us	ian/		2 Fetal death 3	Ectopic pregnancy			23d. Date of deliv Month	ery Day Year	
o.	at the de by the a tached t	Physician/Me	1 Yes 2 No 4 Pregnant a 9 Unknown 9 Unknown	at time of death 5	Other (specify)					
Δ.	res that I igned by be deta		Part II. Other significant conditions contributing to death	but not resulting in the un	iderlying cause given in F	Part I.	23e. Did toba	acco use contribute to t	he cause of death?	
Vital Records,	uires Isign Id be	d by	^		UTAL OFFUS		1 ☐ Yes	s 2 No 3 Prol	pably 4 Unknown	
00	w requir s been si should I	lete					24a. Was an	24h Ware auto	ppsy findings available	
Re	The lavate has page 2	Completed					autopsy perform	prior to co ed? death?	mpletion of cause of	
ta		O	25. Was case referred to medical		26	Place of Death (1 Yes 2		2□ No	
	S S	To B	examiner? 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpati	ent 2 ER/Outpatient	Other		14.00	nce 6 Other (Specif	iv)	
Division of	ng Ph ter th		27. Manner of Death 1 Natural 5 Pending (Month, Da	ury 28b. Time of Injury	28c. Injury at Work?	200		v injury occurred	,,	
Sio	Attanding r death. ector: After	atle	Accident investigation		M 1 ☐ Yes	2 🗌 No				
Ξ	of or Attand after death Director: /	Certification;	3 Suicide 6 Could not be determined 28e. Place of In building, e	jury - At home, farm, stre tc. <i>(Specify)</i>	et, factory, office	28f	Location (Street). City or Town,	eet and Number or Rural Route Number, State)		
	Hospital of the sale of the sa		M 0 - 7 - 1 - 7 - 1							
	Hos 24 hc Fun stely t	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis one and manner significant forms.	of examination and/or inv	occurred at the time, dat estigation, in my opinion,	te and place, and , death occurred	I due to the cat at the time, dat	use(s) and manner as s se and place, and due to	tated. the cause(s)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Med	one) and manner st	widy.	29c. License num	ber	29	d. Date signed (Month,	Day, Year)	
	P S P O		Day my 11	.)~	0305			-5-04	,	
	18		30. Name and address of person who completed cause of	death (Item 23a) (Type, F						
	1		200 K Wintoug, W.	D 11065 L	Hie Patoxr	+ Parle	way , (,	alumbia Mp	21044	
	Sta Registr				back				· · · · · · · · · · · · · · · · · · ·	

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Susan O'Neal 2:45 a. April 3, 2004 Yeer **Physician** 4b. City, Town, or Location of Death Ellicott City /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Howard 9805 Jessica Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 393.54.021 June 23, 1964 Director Wisconsin Usual Residence of Decedent 10d. Inside City Limite the Maryland 10c. City, Town or Location 10b. County 10a. State event, the Medical Executer must be notified at 1 ☐ Yes 2 No Ellicott City Maryland Howard Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A 21042 9805 Jessica Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces!

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Carban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 22 NO White Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working Own Home College (1-4or 5+) Elementary/Secondary (0-12) Homemaker should be filed with ind Mental Hygiene. marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charlotte Koch Henry Kosidowski ္ရ 19a. Informant's Name/Relationship (Type, Print) HUS bund 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 ie m eny injury or other traum once. 9805 Jessica Lane Ellicott City, Maryland 21042 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 Removal from State All County Cremation Services, Inc. 04/06/2004 Sykesville, Maryland 5 Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Service Licensee Moiay Approximate Interval Between Onset and Death 23a. Pen1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Wetastatic Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. | detached 9 Unknown The law requires that the signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, pe 3 Probably 4 Munknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? page 1 🗌 Yes 2M No certificate Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Hospital: 4 ☐ Nursing Home Sesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of or Attending Division 5 Pending Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deal To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide filled Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type. Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 6:02 A.M **JOSEPHINE** PASC0E APRIL 3. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH ARUNDEL HOSPITAL **GLEN BURNIE** ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M & F Days 86 Director 215 - 05 - 1351 JUNE 13, 1917 BALTIMORE, MD Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits or 28a-f show event, the Medical Exeminer must be notified at MARYLAND 1 ☐ Yes 2 XXNo ANNE ARUNDEL Director GLEN BURNIE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 317 WENDE COURT or items 23a 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ∐Yes 2XXINo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes XX No Specify: WHITE Specify: 3(☑ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiene Important: If item 27 ie marked other the any injury or other traumatic event, I'm 1 once. 12 MACHINE OPERATOR AMERICAN CAN CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ALBERT COHLEPP ပ SCHREIBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TONY PASCOE - SON 8172 QUARTERFIELD FARMS DRIVE, SEVERN, MARYLAND 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH CEM. 4/7/2004 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FINK FUNERAL HOME, PA KELLY GREGORY FINK #M01148 426 CRAIN HIGHWAY 5., GLEN BURNIE, MAKYLAND 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician PNEUMONIA /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Physician/Medicai as IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown à ے Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause if death? Division of Vital Records, þ 3 Probably 4 Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed page certificate 1 Yes 2 No the Hospital or Attending Physician: rector, 25. Was case referred to medical Be 26. Place of Death Check only one) Hospital: 1 Inpatient 2 □ ER/Outpalient 3 □ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kassahun 0005597 APRIL 03,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11500 Sulherland Desse Silver Spring MD 20904 Zeieke HILL Way 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 6 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. UU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Year April 750 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospita 6 Battmore
If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□ F 251-56-4992 Usual Residence of Decedent Yrs. Director South Carolina the Maryland 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location show treumetic event, the Mudical Examiner must be nutified at 1 XYes 2 No Director 28e-f Maryland MOTE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō Pages 1 and 2 should be filed within 72 hours after death winent of Heatth and Mental Hygiene. nnt: If item 27 is marked other than "naturel", or Items 23a ber Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Completed by Specify: Specify: ${\cal F}$ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) river 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 19a. Informant's Name/Relationship (Type, Print) State, Zip Code) 4912 Department of Health Importent: If item 27 rendergra 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 Woodlawn Cemetery A ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liopnsee 22. Name and Address of Famility any 2222 W, NORTH AV Part) Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 4 24 hours disease or condition resulting in death) mound /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medlcal Records, P.O. Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown n signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No Vital 1 Yes 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Division 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

62. Registrar's Signature

31. Date filed (Month, Day, Year) APR 6 2004

			For State Registrar	State of Marylan	d / Depa		lealth and l	Mental Hygi	ene g. No. 20	04 1036	
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) Constance Palm 4a. Fecility Name (If not institution, give s	nisano		4b. City, Town, o	r Location of Death	1 1 1 1 1	_		
	Funeral Director	ier	University of Marylar 5. Social Security Number 6. Sex	rel Medical Ce		Balty If Under 1 Year Months Days	vere	8. Date of Birth (Month, Day, March 4	N/A	Birthplace (State or Foreig Country) Maryland	
	Ba-f ahow	Director	10a. State 10b. County Maryland Baltimo	ore Mo	y, Town or Lo	Park				10d. Inside City Limits 1 ☐ Yes 2 🌠 No	
de deine de	23a or 2 lat be n		10e. Street and Number 2100 Whistler Ave	•		10f. Zip Code 2123	0		g. Citizen of Wha	it Country?	
hours offer dooth with the Mendonia	ral", or items 23a or 28a-f ahow Exeminer must be mulified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U. Armed Forces? □ Yes	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No		pecify Yes or No- p Rican, etc.)		American Indian, White, etc. White	
within 70	ene. than "na he Medic	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor d)	king	Sb. Kind of Busin	•	
politor produce of	d othe	To Be Co	17. Father's Name (First, Middle, Last) Clifford Uhl		Homen	lakei	18. Mother's Nam	ne (First, Middle, Ma Sadler	Own Hom aiden Sumame)	e	
	atth and 27 is me		19a. Informant's Name/Relationship (Type Rickey Baker, Sr.		19b. Mailir 21	g Address <i>(Street</i>)		ral Route Number, Baltimon		te, Zip Code) 21230	
C Page 1 2	エラモ		20a. Method of Disposition 1	emoval from State	emetery, cren	sition (Name of natory or other place 1 Cemete:	· 1		oc. Location - Cit Glen Bur		
firmou	Depart Import any inj		21. Signature of Funeral Service License	Bul		Name and Address Mbrose Fi 328 Sulbr		me, Inc.	hutua 1	MD. 21227	
the he executed	ate be executed Medical Examiner Ine burial-transit	dicai Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Lisease or injury that infliated events resulting in death) Last	Sep 515 Due to (or as a consequ	ience of):					Interval Between Onset and Death	
the death certifica	been signed by the attending ph should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	Bc. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year	
requires that the	en signed b		Part II. Other significant conditions conf	tributing to death but not resu	iting in the ur	derlying cause give	en in Part I.			e to the cause of death? Probably 4 Cunknown	
The la ate has page 2	ate has page 2	Completed						24a. Was an autopsy performa 1 Yes 2	d? 24b. Were prior death		
ding Physician:	this al di	tion: To Be	27. Manner of Death 1 Natural 5 Pending	ospital: 1 X Inpatient 2 1 8a. Date of Injury (Month, Day Year)	26. Place of Death (Check only one) □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 28b. Time of Injury at Work? M 1 □ Yes 2 □ No						
ital or Attending	within 24 hours after death. To the Funeral Diractor: After completely filled in by the funeral	Certification:	2 Accident						31. Location (Street and Number or Rural Route Number, City or Town, State)		
To the Hospital or	n 24 hou he Funei pietely fii	Medicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the tim estigation, in my op	ie, date and place, pinion, death occur	and due to the caused at the time, date	se(s) and manner and place, and	r as stated. due to the cause(s)	
Tot	vithii Comp	Ž	29b. Signature and title of certifier	_ mo		29c. License		29d	Date signed (M.	Onth, Day, Year)	
	Sta Registr		30. Name and address of person who con Carric Himes Un 31. Date filed (Month, Day, Year)	IVEISI A Mor	lond	Medical 3	iyətem 2	2 Saith	Greene S	treef Balton	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** ll:a Pendleton 3 2004 Shirley /Medical 4c. County of Death 4b. City, Town, or Location of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore NA 1327 Gorsuch Ave. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🕱 F Director 68 10-19-35 Va. 213_32_885 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event. If a Medical Examiner must be notified at M☐Yes 2☐No Director Md. NA Baltimore 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21218 USA 1327 Gorsuch Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Factory Laborer 9th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKN Harris Rose Gregg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1327 Gorsuch Avenue, Baltimore, Md. Husband Freddie Pendleton 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Nurial 2 Cremation 3 Removal from State Dulaney Valley Cem. 4-7-04 Timonium, Md. *4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. april March F.H. East 1101 E. North Ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ONIC NAL /Medical Due to (or as a consequence of): **Examiner** 1000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last C. Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy tor in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has I autopsy performed? Yes 2 X No 1 Tes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one examiner: Other: 1 Yes 2 No 1 Inpatient 2 EN/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) Certification; To Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funerel Director: the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cepties 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 0 6 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6:47 Grace R. March 30, 2004 /Medical Baltimore City

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day)

March 11,1916 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospita Sinai 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔭 F 266-01-5480 88 Yrs. Florida Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show 1 ☐ Yes 2 ☐ No Directo Maryland **Baltimore** Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 6825 Campfield Road 21207 United States or Items 23a Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status other traumatic event, the Medical Exertiner 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be fited within if Health and Mental Hygiene. Elementary/Secondary (0-12) Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dublin S. Register Ophelia E. Donaldson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) F. Paul (Son) Edwin 212 Homevale Road, Reisterstown, MD. 21136 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of It
Importent: If ite
eny injury or of 1 Burial 2 Cremation 3 Removal from State Harrisburg Cemetery 04/03/04 *4 ☐ Donation 5 ☐ Other (Specify) Harrisburg, PA.17103 21. Signature of Funeral Service License 22. Name and Address of Facility Loring Byers Funeral Directors 8728 Liberty Road, Randallstown, MD. 21133-4784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ante hours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death jo in the past 12 months?
1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. I 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown as been signal 2 should b 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? this certificate ha 2 No 1 Tyes To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Furierel Diractor: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

Registrar

31. Date filed (Month, Day, Year) APR 0 6 2004

no de

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

02

29d. Date signed (Month, Day, Year)

30, 2004

			i lease i	State of Maryland	d / Department of Health an	d Mental Hygien	e	
			T State Registrar	otate of warytant	Certificate of Death	Reg. N	-2006	10363
	Physicia	an	1. Decedent's Name (First, Middle, Last) A M V	£1	Ross	2. Date of Death Month D	ay Year,	3. Time of Death
	/Medic Examin	al	4e. Fecility Name (If not institution, give st		4b. City, Town, or Location of D	eath 4	c. County of Deet	61.11
	Examin	er	1 71 11 1	ins Hospital	Bultimore Cit	4	NIF	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. la M 2 F /2 Q	ast birthday) If Under 1 Year If Under 24 Months Days Hours M	Ain. A Date of Birth Ain. A Month, Day, Yea	9. Birth	hplece (State or Foreign untry)
	<u>D</u>		Usual Residence of Decedent	103		719917,1		argreeria
	Aarylan f ahow	ō	10a. State 10b. County	10c. City	Town or Location			10d. Inside City Limits 1 Yes 2 No
	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or flems 23a or 28a-f ahow avent. I're Medical Examinat must be nutified at	Funeral Director	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Co	ountry?
	eath wi	eral	1937 E. NOT	2. Was Decedent Ever in U.S	S. 13. Was Decedent of Hispanic Origin	? (Specify Yes or No-	14. Race - Ame	rican Indian,
9	atter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ▼Yes 2 □ No 11 Yes, Give	If Yes, specify Cuban, Mexican, P 1 Yes 2 No Specify:	uerto Rican, etc.)	Black, White	
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215-	in 72	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind of work done during most of life. DO NOT use retired)	working	Killa of Busiliess	industry
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Maryland	ould be fill Mental Hy karkad oth katic avan	Be	17. Father's Name (First, Middle, Last)		18. Möther's	Name (First, Middle, Maide	in Sumame)	n c n n
ary	should and Me s mark umatic	P_C	19a, Informant's Name/Relationship (Typ	Do. Prini) daughter)	19b. Mailing Address (Street and Number of	r Rural Route Number, City	or Town, State, 2	Zip Code)
- 10	ges 1 and 2 should tof Health and Mer If Itam 27 is marks or other treumatic		Ms. Teresa	Ross	22 N Spring	St. Balt	o, Md.	2/23/
Jore	Peges 1 nent of H int: If Ital		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	lace of Disposition (Name) of emetery, crematory or other place)	S-2004 0	Location - City or	Town, State
Baltimore	그 등 환경		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lipense		Cr. Son Forest		o ngs n	in is, ma.
ä	Depa Impo any ic	1	pseph	L' Kis	1 2222 W North	Ase Baits	a mam	21216
**			23a. Part / Enter the disease, or complic shock or heart failure. List only on Immediate Cause (Final		Do not enter the mode of dying, such as car	diac or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as e consequ				10 inswites
	Examiner		Sequentially list conditions, b.	MYULARO				3 days
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):			,
Q/	be executed icien and burial-transit		that initiated events c. resulting in death) Last	Due to (or as a consequ	vence of):			
68760	0 5 0	edical	d	•				
Box 6	leath centificate t attending physi I for use as the b	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna			23d. Date of del	ivery
	The law requires that the death certificat ate has been signed by the attending phy page 2 should be delached for use as th	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown			Month	Dey Year
P.0	that the			tributing to death but not resu	ulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
Vital Records,	w requires been sign should be	ed by	COROHARY as	ALERY GISENSE		1 🗆 Yes	2□No 3□Pr	obably 4 Munknown
eco	law re las bee	ompieted				24a. Was an autopsy	prior to o	stopsy findings available completion of cause of
al R	: The licate ha	O				performed? 1 ☐ Yes 2 🖫		2□ No
Vit	Physician: Tribis certificated Interpreted in the certificated in the control of	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2 I	Other	Death (Check only one)	6 □Other /Soe	cify)
n of	ng Phys fter this neral di	-	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of linjury at Work?	28d. Describe how in		
Division	Attsnding P death. octor: After t y the funera	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of Injury - At ho	M 1 ☐ Yes 2 ☐ No	28f. Location (Street)	and Number or Ru	ural Route Number.
Οi	iel or Attandir s after death. al Director: Ai ed in by the fu	Certification:	4 Homicide determined	building, etc. (Specify		City or Town, Sta		
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical			wledge, death occurred at the time, date and p tion and/or investigation, in my opinion, death of			
	Fo the vithin 2 to the comple	Med	29b. Signature and title of certifier	W?	29c. License number		Date signed (Monti	
	41		JAVID MOSLENT	MEDICAL	DOCTOR RES.	600	April :	2,2663
	10	1	30. Name and address of person who co	mpleted cause of death (Item	123a) (Type, Print) WELFE (FREET B	ALTEMORE	MARYLAN	7 21227 -9106
	Sta	ate	31. Date filed (Month, Day, Year)	32 Begistrar's Signa	Ture 3 (#CC)			
	Regist	rar	APR 6 2004	General B	Sports			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

					State o	or mar	yland / I		triment o tificate d		ealth and N Death	_	_	2001	. 1	0361
	D		1. Decedent's Name (First, Midd	ile, Last)							2. Date of De		Year	3. Ť	ime of Death
	Physicia /Medic		Eleanor Rose	nber	g							March	29, 2	2004	5:	30 PM
1	Examine	-	4a Fecility Neme (If not institution Beverly Heal			mber)					o. City, Town, <i>o</i> r Lo Frederic		h 4c. (County of Deel Freder		
	Funeral Director		5. Social Security Number 579–26–6584	6. Se	x]M 2⊠F		(In yrs. last bii 96	rthday) Yrs.	If Under 1 Ye Months Da		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Apr 7,	1907	9. Bird Co Ma	hplace (Sountry) ryla:	State or Foreign
	p ,		Usuel Residence of Decedent				0. 0. T									
	Manylar n-f show	ţo	MD 10b. Count	•	ck		loc. City, Tow		lerick						ĺ	ide City Limits Yes 2 No
	or 28	2	10e. Street end Number						10f. Zip Coo	de			10g. Citiz	zen of What Co	untry?	
	23e	a	30 North Place	:							702			USA		
020	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or frems 23a or 28a-f show other traumatic event, the Medical Examiner must be nothed at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☒ Widowed 4 ☐ Divorce	1	12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Yeer or D	orces? 2 (XNo ive	er in U,S.	1	Vas Decedent fYes, specify C ☐ Yes 2 <mark>1</mark> 7		spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		I4. Race - Ame Black, Whit Specify: W		
5-0	72 ho	it g	15. Decede (Specify only high	nt's Edu	cation		16e	. Deced	lent's Usual Oc	ccupa	tion	ina	16b. Kin	nd of Business/	Industry	
121	within ene.	Completed by	Elementery/Secondary (0-12)		College (ephone		aring most of work	"' 9	Ual:	+o* Doo	ם זו ב	amital
9	2 should be filed within and Mental Hygiene. Is marked other than raumetic event, tra Mental tra Mental tra Mental tra Mental tra Mental tra Mental tra Mental tra Mental tra Mental tra Mental tra Mental tra Mental tra Mental tra Mental tra Mental tra Mental tra Mental tra Mental tra		17. Father's Neme (First, Middle		ı.K			LEI			18. Mother's Name	e (First, Middle	Maiden S	ter Ree Su <i>rname</i>)	а но	spital_
<u>a</u>	12 should be f h and Mental t is marked of traumatic eve	To Be									Viola C					
ary	shou and M	_	19a. Informant's Name/Relation				19t	. Mailin	g Address (Str	reet a	nd Number or Run	ei Route Numb	er, City or	Town, Stete, 2	(ip Code	
Σ	Health (sem 27 is other tra		Les Rosenberg	/son	L						rse Circ	le New	Marke	et, MD	2177	4
Baltimore, Maryland 21215-0020	8 = 5	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) in state									cation - City or	Town, Sta	ate			
Ball	permit. Par Department Important: any Injury once.	21. Signature of Euneral Sarvice Licensee Ronal of S. Wade Director State Anatomy Board 655 W. Baltimore Baltimore, MD 21201									timore	Stre	et			
· All	Physician		23a. Parti. Enter the disease of shock, or heart failure. Lis	or complete only of	cations that one cause on e	caused the	e death. Do	not ente	or the mode of	dying	, such as cardiac	or respiratory a	rrest,	1 1	Interv	ximate al Between and Death
The second	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	i a	pr	neumo	nia bi	ilat	eral						10	days
		ner	vocating in country		de		ue to (or es e ia alz		uence of): mer typ	pe] 	У	rs
,0	ficate be executed physician and as the burial-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that injury and the control of th	ſ	hy		e to (or as e ensior		uence of):						у	rs
k 68760,		8	that initiated events resulting in death) Lest		de		e to (or as e o		uence of): int dis	sea	se				У	rs
. Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/M	Part II. Other significent condit	ons cor	itributing to de	eath but r	not resulting in	n the un	deriving cause	oive	n in Part I.	23b. Did	tobacco u	use contribute	to the ca	suee of death?
P.O.	res that the de signed by the a be detached i	Phys	renal insuffi	cien	cv. in	cont	inence	11	mmohili	+ 17		1 🗆	Yes 2	KNo 3□PI	obably	4 🗆 Unknown
rds,	uires f	o o						-,				24a. Was	an autops			opsy findings
eco	law require tas been signs 2 should t	Completed	syndrome, ane	mia,	hypoa	1bum	inemia	ı, i	nsomnia	1		perfo	rmed?		vailable completion of death?	n of cause
=		5										101	Yes 22	No	□Yes	2 No
VIII.	ysician: The is certificate I director, pag		25. Was case referred to medic examiner?	-	lospital:					Other	26. Place of Deatl	7				
jo	this ald	0	1 ☐ Yes 2 😿 No 27. Manper of Death		28a. Date		2 ☐ ER/Oι	utpatien! Time <i>o</i> f	3LI DOA		4 De Nursing Ho	me 5 Residente R			cify)	
0	ding Th. After fune	틸	1 Natural 5 ☐ Pendi	ng igation	(Mon	th, Dey Y		Injury	28c. li		es 2□No	200. 0000.00	io ii ii iio iy	00001100		
Division of Vital Records,	I or Attending after death. Director: After din by the fune	Certification:	3 ☐ Suicide 6 ☐ Could	_	28e. Place buildi	of Injury ing, etc. (- At home, fa Specify)	arm, stre	et, factory, offi	ice		28f. Location (City or Tox	Street and vn, State)	l Number or Ru	ral Route	Number,
	Hospi 24 hou Funer tely fill	edical C	29a. Certifier 1X Certifyi (Check only one) 2 Medica	ng Phye I Examii	ner: On the ba	best of rasis of ex ner state	camination en	e, deeth id/or inv	occurred at the estigation, in m	e time ny opi	e, date end place, a nion, death occurr	and due to the ed at the time,	ceuse(s) a date and p	and manner as place, and due	stated. to the ca	use(s)
	vithin 2 To the comple	×	29b. Signature and title of certifi	er	1.1	11.	no	6	29c. Lic	ense	number		29d. Date	signed (Montl	n, Day, Yo	ear)
			Allen	10	eil	ey	1 /16			474	49		Marc	h 30, 2	2004	
-			30. Name end address of person			/ /										
			Allen Reilly 31. Date filed (Month, Day, Yeer				lace F	rede	erick,	MD_	21701					
	Stat Registra	6	APR 0 6 2			egistrer's		,	books	1						

			Flease	State of Manuar				•	-	
			For State	State of Marylan		ment of F ficate of			2000	10365
			Registrar 1. Decedent's Name (First, Middle, Last)		00711	neate of	Deatit	2. Date of Death	g. No.	3. Time of Death
	Physici /Medic		JOHN	CURTIS	RE	EIBER		March	Day Year 31 2004	7.45 PM
	Examir		4a. Fecility Name (If not institution, give s	11-10/0	10/010	b. City, Town, o	or Location of Death)	4c. County of Deat	h
	Funeral		Franklin Square 5. Social Security Number 6. Sex	7. Age (In yrs.		f Under 1 Year) Se Oa 6 If Under 24 Hrs.	8. Date of Birth (Month, Day,	1541+ 9. Birt	hplace (State or Foreign untry)
	Director		218-80-175+ 150 Usual Residence of Decedent	M 20F	J Yrs.	Months Days	Hours Min.	APRIL 4	1361 M	HRYLAND
	anyland show		10a. State 10b. County	10c. City	y, Town or Local	_				10d. Inside City Limits
	he Ma	ector	MARYLAND BALTIM	ORE 1	TIDDLE	RIVE	ie			1 ☐ Yes 2 💢 No
2	death with the Maryland ms 23a or 28e-f show Et and be notified at	Funeral Director	10e. Street and Number 1501 RECK LOV	VAVENUE		10f. Zip Code	20	10	g. Citizen of What Co	untry?
0	r death	nera		Was Decedent Ever in U. Armed Forces?	S. 13. Wa	s Decedent of H	tispanic Origin? (Spo an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	rican Indian,
5-0036	is 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Membel Hygiene. The file is marked other than "natural", or items 23a or 28e-f show other treumatic event, the Madical Extending Internal the routilised at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Yes 2 No	Specify:		Specify:	/H17E
	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	eation completed)	(Give kin	t's Usual Occup d of work done	during most of works	ng 1	6b. Kind of Business/I	ndustry
7	filed within Hygiene. ther then "	ошр	Elementary/Secondary (0-12)	College (1-4or 5+)	6 1	NOT use retired	*		NURSING	HOME
	filled Hyginother ent,		17. Father's Name (First, Middle, Last)		I Illia		18. Mother's Name	(First, Middle, M		1101010
0 1	ild be lental ked c	To Be	WILLIAM H. R	CEIPER, S	2.		ISARE	FRA	NCES BE	SACLI
Maryland	2 should be and Mental Is marked o	-	19a. Informant's Name/Relationship (Typ	e Print)	19b. Mailing	Address (Street	and Number or Rura		City or Town, State, Z	ip Code)
500	1 and 2 Health a 6m 27 Is		BARBARA L. KARAYIN	VOPULOS/SISTER	1512	CEDAR	POINT DA	VE FAST	PEODVIVII	IF MD 21903
2	of Hee	3	20a. Method of Disposition	20b. P	lace of Disposition	on (Name of	- 3(13)	ate 2	0c. Location - City or 1	m 1
E	Pages nent of I int: If its		1 Burial 2 □ Cremation 3 □ Re 1 Donation 5 □ Other (Specify)	moval from State	RKNDOD	CFOACE	TON ADD	a some	PAONVILL	EMI
Baltimore	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr	- 7	21. Signature of Funeral Service License			ame and Addres	ss of Facility	ANS EN	NERAL C	NADET
ä	Depa Impo sny ii	y 1	Kimbellial	Balliote	- 0	200 HA	REFOR RIVA	n Dage	VILLE MD	21234
	-		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the death	Do not enter t	he mode of dyin	g, such as cardiac o	r respiratory arres	VILLE, MO	Approximate
	Physician		Immediate Cause (Final	cause on each line.	L-12	CALA	1)	cer		Interval Between Onset and Death
Y	/Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):	Color	1 00(1)	CEI		
	Examiner			Brain A	10 tast	nses				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):					
	cutec nd ransi	Examiner	that initiated events C.							
760.	te be executed ysician and te burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):					
376	ate be hysici	icat	d.							
Box 68	leath certificate attending physical for use as the total for the total	Med	IF FEMALE:							
9	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3 □Ec	opic pregnancy			23d. Date of deliv	
	the a	Physician/Medi	1 Ves 2 No	4☐Pregnant at time of de 9☐Unknown	eath 5 □ Ot	her (specify)			Month	Day Year
a.	uires that the de signed by the a		Part II. Other significant conditions cont	ributing to death but not resu	iting in the unde	riving cause give	an in Part I	23e Did toba	cco use contribute to	the cause of death?
rds	tuires n sign	Completed by	Acute Brong	chitis		, g g			b_4	bably 4 \(\sum \text{Unknown}\)
CO	s been si	ojete						24a. Was an	24b. Were auto	posy findings available
B	sicien: The law certificate has b irector, page 2 s	mo						autopsy performe 1 Yes 2	g? death?	opsy findings available impletion of cause of
ita	ysicien: us certifica director, p	BeC	25. Was case referred to medical examiner?				26. Place of Death	/		2 140
<u></u>	ysic nis ce	To	1 ☐ Yes 2 No	ospital: 1 Inpatient 2 🗆 E	ER/Outpatient	DOA Othe	er: 4 Nursing Hon	ne 5 Residen	ce 6 □Other (Speci	fy)
UX C	ng Pl		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2	8d. Describe how	injury occurred	
× .0	Wtendii death. ctor: A y the fu	ath	2 Accident investigation				Yes 2□No			
Division of Vital Records. P.O.	Hospitel or Attending Physicien: The law requires that the death certificate be executed 9.4 hours after death. Funeral alter death. Funeral Director: After this certificate has been signed by the attending physicien and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street,	factory, office	2	8f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
	ours seral l		29a. Certifier 1 Certifying Physi-	cian: To the best of my know	yledge death on	overed at the time	o data and place a	and due to the	(-)	
	To the Hospitel or Attending Ph within 24 hours after death To the Funeral Director: After thi completely filled in by the funeral	Medical	(Check only 2 Medical Examine one)	er: On the basis of examinati and manner stated.	ion and/or invest	gation, in my or	pinion, death occurre	d at the time, date	and place, and due t	o the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier			29c. License	number	29d	. Date signed (Month,	Day, Year)
	\ .		1 Xella	naclaw	MD	DY	1530	3	3-31-	2004
	V		30. Name and address of person who com	repleted cause of death (Item	23a) (Type, Prin	NDPin	ER CIR	CUE S	UITE 211,1	2004 2004 UD-21236
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure A	Courte	/			70
- 1	Registra	ar	APR 0 6 2004	1 Parent	1 /					

		1 - For State Registrar	State of Mary		artment of I <i>rtificate of</i>			jiene •g. No. 20(14 103
Physici /Medi		1. Decedent's Name (First, Middle, Las MARY SEUF	ERT				2. Date of Deat Month APRIL	Day Yea	. 0111 10
Examir		4a. Fecility Name (If not institution, give	street and number)	TER	4b. City, Town, a	or Location of	Death	4c. County of D	
Funeral Director		210-01-0139	7. Age (In	yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	8. Date of Birth (Month, Day, May 6,	9. E 1919 MD	Birthplace (State or Fore Country)
a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Anne Aru		c. City, Town or Lo					10d. Inside City Lin
3a or 28 at the rig	I Director	10e. Street and Number 7941 Crownsway			10f. Zip Code 2106	1	11	0g. Citizen of What	Country?
al', or Items 2 Examiner na	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 [] Yes 2\frac{\frac{1}{2}}{2} \text{No} If Yes, Give Year or Dates:			Hispanic Origi an, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)		merican Indian,
nene. r than "natur The Medical	Completed	15. Decedent's Edi (Specify only highest grace Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire chasing I	during most (d)	of working	16b. Kind of Busines Baltimore Form	
Mental Hyg Marked other Matic event,	To Be C	17. Father's Name (First, Middle, Last) William Vincent				18. Mother Lore	s Name (First, Middle, A	Maiden Sumame)	
Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23e or 28e-f show sny injury or other traumatic event, the Medical Examinatings he multiled at once.		19a. Informant's Name/Relationship (T) Mr. Thomas McHale 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other ⟨Specify⟩	/ nephew 2	3247 Ob. Place of Dispo	Sykesvi] sition (Name of natory or other place	le Roa	Apr 5		21157 or Town, State
Departm Imports any inju		21. Signature of Funeral Service Linns		12/ 22	. Name and Addre	ss of Facility	Singleton E S.W., Glen	Funeral Ho	ome P.A.
ysician ledical aminer	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if a.y, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitiated events	ne cause on each line.	ARBIA	_	ARCT		St,	Approximate Interval Between Onset and Death
rattending physician and I for use as the burial-transit	d								
ed by the atter detached for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	-		23d. Date of de Month	elivery Day Year
been signed I should be det	þ	Part II. Other significant conditions cor	ntributing to death but not	t resulting in the un	derlying cause give	en in Part I.			to the cause of death?
ate has page 2	e Completed	25. Was case referred to medical						prior to death? No 1 ☐ Ye	utopsy findings availal completion of cause o s 2 \(\sum \text{No} \)
(2 E)	To B	examiner? 1 ☐ Yes 2 💢 No		2 ER/Outpatient	3□ DOA Othe		Death (Check only one)		ecify)
ctor: After	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea		M 1 🗆	rat c? Yes 2 □ No	28d. Describe how	injury occurred	
, m =		4 Homicide determined 29a. Certifier 12 Certifying Physics	28e. Place of Injury - / building, etc. (Sp	knowledge death	occurred at the tim	- bes steb as	City or Town,		
	edicai	one)	ner: On the basis of exam and manner stated.	nination and/or invi	estigation, in my op	oinion, death o	occurred at the time, date	e and place, and du	e to the cause(s)
o the Fu		290. Signature and title of certifier					1 290	d. Date signed (Moni	
50	2	29b. Signature and title of certifier 30. Name and address of person who co	layer		RES	001		IPRIL - 2-	

			1 - For State Registrar	State of Marylar		artment of Health a		iene _{9. No.} 2004 10367
	Physici		1. Decedent's Name (First, Middle, La Janet Fendal)	-			2. Date of Deat Month	Day Year
	/Medi Examir		4a. Facility Name (If not institution, given	e street and number)		4b. City, Town, or Location of Silver Sprin	of Death	4c. County of Death Montgomery
	Funeral Director			ex 7. Age (<i>In yrs.</i>		If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Birth (Month, Day, NOV 27,	Year) 1944 9. Birthplace (State or Foreign Country) Unk
	Maryland febow	tor	Usual Residence of Decedent 10a. State 10b. County MD Montgot		ity, Town or Lo	cation er Spring		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 28e	i Director	10e. Street and Number 11600 Stewart	Lane #103		10f. Zip Code)904	Og. Citizen of What Country? USA
980	72 hours after death with the Maryland neturel; or Items 23a or 28e-1 ehow deal Examinar must be mutified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		Mas Decedent of Hispanic Ori f Yes, specify Cuban, Mexicar □ Yes 2 □ No Specify:		14. Race - American Indian, Black, White, etc. Specify: black
1215-0	d within 72 hours piene. r than "neturel", the We died Ex-	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during mos DO NOT use retired)	t of working unk	16b. Kind of Business/Industry unk
Maryland 21215-0036	be filed ntal Hygi od other event,	Be	unk 17. Father's Name (First, Middle, Last)	unk		unk 18. Mothe	er's Name (First, Middle, N	faiden Sumame) unk
Mary	nd 2 shou lith and M 27 is mar	2	19a. Informant's Name/Relationship (Montgomery Police		19b. Mailir	ng Address (Street and Number	ar or Rural Route Number,	City or Town, State, Zip Code) unk
Baltimore,	Pages 1 ar nent of Hea int: If item 3 iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ⚠ Other (Specify	Removal from State	Place of Dispo cemetery, crer	sition (Name of natory or other place)	Date 2	20c. Location - City or Town, State
Balti	permit. Page Department Importent: If any injury o		21. Signature of Funeral Service Licer Ronal Id S	Director	r St	Name and Address of Facility ate Anatomy Bo 1timore, MD	oard 655 W. :	Baltimore Street
I	Physician		23a. Parth. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the dea	th. Do not ent	er the mode of dying, such as	cardiac or respiratory arre	Approximate Interval Between Onset and Death
ı	/Medical Examiner	_	resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a consec				my
8760,	ate be executed oblysician and the burial-transit	dicai Examiner	in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consec				
.O. Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet: 4 Pregnant at time of 6 9 Unknown	aldeath 3□	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	es thaigned	ρ	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause given in Part I.		acco use contribute to the cause of death? s 2 \(\sum No \) 3 \(\sum \) Probably 4 \(\frac{1}{2} \) Onknown
Division of Vital Records,	The law ate has b page 2 sl	Completed					24a. Was an autopsy perform	prior to completion of cause of death?
Zi:	Physician: 1 r this certifical ral director, p	To Be	25. Was case referred to medical examiner? 1 XYes 2 No	Hospital: 1 Inpatient 2	EB/Outnatien	Othor	of Death (Check only one rsing Home 52 Resider	
ion of	Attending Physic death. sctor: After this by the funeral di		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 1	28d. Describe how	
Divis	i Pite	Certification:	3 Suicide 6 Could not by determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, stra fy)	eet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)
	he Hospital or n 24 hours afte he Funeral Dir pletely filled in I	Medical	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowning. On the basis of examination and pranner stated.	owledge, death ation and/or inv	occurred at the time, date and restigation, in my opinion, deat	d place, and due to the car th occurred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	echimo.	ME	29c. License number	8 29 Y	d. Date signed (Month, Day, Year) Nar 29 2004
			30. Name and address of person who ILR N BRE		m 23a) (Туре,	Print) 2101 ME	Sprem	1K P1 mn 20902
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	Solver Sparks		

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 March 20, **Physician** Edith M. Smith 5:00 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 109 S. Hilltop Road Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept 8, 1923 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6 Sax 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕅 F 217-18-0842 80 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fahow is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or Itama 23a or 28a-f ahov other traumatic event, the Medical Examinar must be notified. MD Baltimore 1 ☐ Yes 2 ☑ No Director Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 S. Hilltop Road Completed by Funeral IISA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jerome McGovern Mary Moody 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s tment of Health an Susan Hull/daughter 109 S. Hilltop Road Catonsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of I important: If ite any Injury or o 1 Burial 2 Cremation 3 Removal from State 21. Signature of Europeal Service Licensee Ronald S. Wad 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 rector 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Jon-Small cell lung cancer months /Medical Due to (or as a consequence of): Examiner from the following the following from the first any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE esn. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy ŏ Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 99 12Yes 2 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify NOV & C Hospital: 1 Tes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of injury (Month, Day Year) 28c. injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Naturai death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deati To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signatufe and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 035354 30. Name and iddress of person who completed cause of death (Item 23a) (Type, Print) 900 Patra ave BALT 1100 21229 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar APR 0 6 2004

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Scarberry 7: 07 AM April 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner City Hospital Baltimore The Johns Hopkins If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept. 951 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 183-44-8803 7. Age (In vrs. last birthday) **Funeral** 1 M 2 K 52 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or Items 23e or 28e-f show the Medical Examinat must be notified at 1 Yes 2 No Maryland Carroll **Funeral Director** Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 356 W. Sawmill Rd. 21158 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z.No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene. nent if item 27 is marked other than "natural; or lite any or other thaumatic event, the Medical Examina 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary (0-12) College (1-4or 5+) Housewife Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Donald Boone Catherine Cool 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tommy Ray Scarberry - husband 356 W. Sawmill Rd. Westminster, Md. 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Metro Crematory April 7,2004 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore. Md. 21. Signature of Funeral Service Licensee Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, Tehl Hank Md. 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) small cell lung **Physician** metastaho 2 years /Medical Due to (or as a consequence of): Examiner days hepatic failure sa uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed hours failure respiratory and Due to (or as a consequence of): attending physician for use as the buria Box 6876 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ peq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 No certificate Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient မ 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Wiso Mountle MD April 4, 2004 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe Street, Baltimore, Maryland 21287 Nisa Maruthur 31. Date filed (Month, Day, Year) APR 6 2004 32. Registrar's Signature State oaks Registrar

			For State Registrar	State of I	Maryland / D	epartment Certificate			nd Men		iene2	004	10370
	Physicia	_	1. Decedent's Name (First, Middle,		SMITH				2. 0	ate of Deat	h Day	. 7004	3. Time of Death
H	/Medic Examin		4a. Facility Name (If not institution, Northwest Lo.	give street and numb	er)	4b. City, To	own, or l	Location of	Death			nty of Death	
	Funeral Director		219-40-1537	6. Sex 7. 1 □ M 2 🙀 F	Age (In yrs. last birt	hday) If Under 1 Months /	Year Days	If Under 2 Hours	Min. (/	ate of Birth Month, Day, b 21,	Year) 1943	Cour	place (State or Foreign ntry)
	anyland show	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr		· ·					1	0d. Inside City Limits 1 ☐ Yes 3 ☐ No
	with the M a or 28e-1 be notifie	Direc	MD Baltim 10e. Street and Number	ore	Randall	10f. Zip C				i		of What Cour	
36	be filed within 72 hours after death with the Maryland at Hygiene. And Hygiene then "neturel", or Iteme 23a or 28e-f show other then "neturel", or Iteme 23a or 28e-f show event, the Medical Examiner must be notified at	by Funerai	5446 Old Court F 11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decede Armed Force	ent Ever in U.S. es? No	13. Was Decede If Yes, specif	nt of His y Cuban	panic Orig , Mexican, Specify:	in? (Specify Puerto Ricar	Yes or No-	14. F E Spe	State Race - Americ Black, White, acify:	can Indian,
21215-0036	e filed withIn 72 hou al Hygiene. other then "neture vent, the Medical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	s Education t grade completed) College (1-4		Decedent's Usual (Give kind of work life. DO NOT use	done du	ıring most	of working		P1a 16b. Kind o	f Business/In	dustry
Maryland 2	2 should be filed and Mental Hygi Is marked other eumatic event, I	Be	17. Father's Name (First, Middle, I Nathan Phears 19a. Informant's Name/Relationsh			Mailing Address (Theol					Code)
d'	and lealth m 27 her to		Ms. Denise Smith 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	n-Daughter 3 □Removal from Sta	20b. Place of	503 Boys Disposition (Name y, crematory or oth	enbe	rry I		Gaith	erbur 20c. Locatio	on - City or To	20879 own, State
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signatur of Funeral Service I	icensee	-5	22. Name and Calvin	Address	Villi.	200 ams Fu	4 I neral	Home	ore, h , P.A. Limore	AD Approximate
,160,	Ite be executed which is the purish reast transit tran	cai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	a a consequence as a consequence as a consequence	etej	or dying	, such as c	ardiac or res	piratory arre	951,		Interval Between Onset and Death
.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 Fetal death it at time of death	3 ☐Ectopic pre 5 ☐ Other (spe						Date of delive	ery Day Year
Ф	quires that n signed by	by	Part II. Other significant condition	ns contributing to deal	th but not resulting in	the underlying ca	use give	n in Part I.			oacco use c es 2 □ No		ne cause of death?
Vital Records,		Completed								24a. Was a autops perforr 1 ☐ Yes	ned? No	prior to co death?	psy findings available mpletion of cause of
of Vita	Physicien: T this certificat ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inp	patient 2 ER/Ou			r: 4□Nui	of Death (Ch		ence 6 🗆		(y)
Division	anding ath, or: After ne fune	Certification:	27. Manner of Death 1	g (Month, jation be 28e, Place of	f Injury - At home, fa	М		? ′es 2 □ N	No 28f. I		reet and Nu		al Route Number,
_	Hospite 4 hours Funerel ely fille	Medicai C	29a. Certifier 1 ertifyin (Check only 2 Medical	g Physician: To the b Examiner: On the bas and manne	is of examination an	, death occurred a d/or investigation,	t the time	e, date and inion, deat	d place, and o	due to the catthe time, d	ause(s) and ate and plac	manner as s ce, and due to	tated. o the cause(s)
	To the lawithin 2: To the complet	Me	29b. Signature and title of certifie	Quies		29c.	_	number 44,	רטז			ned (Month,	
	3		30. Name and address of person	who completed cause	of death (Item 23a)	(Type, Print)	h	0	-	Nec	040	_	roof
	Sta Regist		31. Date filed (Month, Pay, Year) APR 0 6 20		gistrar's Signature	park							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician SON MA /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHRIS If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) TIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 68 Months Days 1 □ M 2 💢 F ado:28.675 APRIL 24 Director NEW Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits BALTIMORE 1 Yes 2 No Directo JARYLAND ARKVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or 2888 SA 31335 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic avent, the Nagines. Elementary/Secondary (0-12) College (1-4or 5+) NGINEERING DOKKEEPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BAHNTEGE MARGARET WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM WALTHER BUD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State *4 □Donation 5 □ Other (Specify) ENETERY APRIL 8, 2014 RIDGE 22. Name and Address of Facility EVANS FUNDRAL 21. Signature of Funeral Service Licen PARKVIL HARFORD RD. 23a. Part1. Enter the diseare, or complications that caused the de-th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dadise on each live. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) chronic dastration leng disesse **Physician** Strage years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (u. as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the Ö 9□ Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? certificate Vital 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 \Batural Injury death. investigation 1 Yes 2 No Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 - Homicide 10 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Bulto, Md GAMC 6701 A 31. Date filed (Month, Day, Year)
APR 0 6 20 32: Registrar's Signature State 6 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Amend Items 2,11,26per Dr., C830,04/28/04dhb Certificate of Death Reg. No. 2. Date of Deeth 04/04/2004 1. Decedent's Name (First, Middle, Last) Month **Physician** NANCY 817 Am SMITH /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner HARFORD 39 EDGEWOOD AVENUE LOVE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 3 - 7 -9 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1□ M 20 F 215-30-4904 Yrs. tennäi Director Ivania Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r Health end Mentel Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** ALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 21234 Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Antoed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🗆 No 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) 8 ${\mathbb B}$ 19b. Mailing Address (Strest and Number of Rural Route Number, City of Town, State, Zip Code) 19a. Informant's Name/Rel tionship (Type, Print) ewood MD 21040 Wendy Kygen 20a. Method of Disposition 1 □ Burial 2 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cametery, crematory) or other 20c. Location - City or Town, State Date ŏ ò 4 □ Donation (5 □ Other (Specify) FOREST HILL, MD EVANS FUNELAL CHAPFU injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WANS FUNELAL CHAPEL or complications that caused the death. Do not ist only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death enter the mode of dying, such as cardiac or respiratory Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner funeral director, page 2 should be deteched for use es the bunel-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, edical Certification: To Be Completed by Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2) No 1 Tes Daughter's 25. Was case referred to medical examiner?

1 Yes 2 □ No 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence Cher (Specify) 2 ☐ ER/Outpetient 3 ☐ DOA After this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 ☐ Accident Injury 5 Pending 1 Tes 2 No investigation efter death. within 24 hours efter death To the Funeral Director: A completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d, Date signed (Month, Dav. Year) 29c. License number 29b. Sigrature end title of certifier mpleted cause of death (Item 23e) (Type, Print EX MA Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2001 10070

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haaith and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show

Baltimore, Maryland 21215-0020

Physi /Mec Exam

To the Hospital or Attanding Physician: The law requiras that the death certificeta be executed within 24 hours after daath.

To the Funeral Director: After this cartificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

			Certificate	oi Dealli	Reg	No. 2004 113/3								
Physician /Medical	Decedent's Name (First, Middle, Last) Frank Shugar				2. Date of Deeth Month March 28	Day Yeer 3. Time of Death 6:15 PM								
Examiner	4a Fecility Neme (If not institution, give str Manor Care Ruxton	eet end number)		4b. City, Town, or L		4c. County of Deeth Baltimore								
Funeral Director	5. Social Security Number 6. Sex 1\overline{\text{2}} 17 - 01 - 1517	7. Age (In yrs. le	est birthdey) If Under 1 Yrs. Months	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Y Dec 17,									
	Usuel Residence of Decedent 10a. State 10b. County MD	10c. City,	Town or Location Baltimore			10d. Inside City Limits 11☑ Yes 2 □ No								
a or 28a- De north	10e. Street end Number 3309 Scauleing Ave		10f. Zip C	ode	10g	Dg. Citizen of What Country?								
Department of Haalth and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		Was Decedent Ever in U,S Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:	S. 13. Was Deceder If Yes, specify	1215 It of Hispanic Origin? (Sp. Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: white								
ygiene. ygiene. ner than "natural", o nt, tre Medical Exan Completed by	15. Decedent's Educet (Specify only highest grade of Elementary/Secondary (0-12)		16e. Decedent's Usual (Give kind of work life. DO NOT use printer	done during most of work retired)	ing 16	b. Kind of Business/Industry unk								
Mental Hyg arked other atic event, To Be C	17. Fether's Neme (First, Middle, Last) Philip Shugar	,		18. Mother's Nam Sarah Y	e (First, Middle, Ma esersky	den Sumame)								
alth and N 27 is men or trsume	19a. Informant's Name/Relationship (Type Herbert Shugar/brot		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6608 Akron Street Philadelphia, PA 19149											
nent of Ha	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ② Other (Specify) in State													
Departimental any injuries.	21. Signature of Eureral Sarvice Licensee Rona Id S. Wa	de Director	22. Name and A State And Baltimon			Baltimore Street								
nysician Medical xaminer	2.1. Pert Lenter the disease or complication of heart failure. List only one of the complete shoot of the comp	shoot, or heart failure. List only one cause on eech line. Interval Between Onset and Death Immediate Cause (Final disease or condition												
within 24 hours after death. To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or righry that nititeded events resulting in death) Last Due to (or es a consequence of): C. Due to (or as a consequence of):													
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gned by the at be detached fo by Physici	Part II. Other significant conditions contrib	uting to death but not result	ting in the underlying cau	e given in Part I.		cco use contribute to the ceuse of death? 2 No 3 Probably 4 Unknown								
ate has been sig page 2 should bi Completed b					24a. Was an a performed	utopsy 24b. Were autopsy findings available prior to completion of cause of death?								
ificate h	25. Was case referred to medical			26 Place of Deat	1 Yes	2万N 1□Yes 21 No								
diract	examiner? 1 ☐ Yes 2 ☐ No Hos	pital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3□ DOA	Other: 4 Z Nursing Ho		a 6 DOther (Capath)								
ath. r: After this na funeral d ation: To				Injury at Work?	me 5 Hesidence 28d. Describe how i	njury occurred								
rs after daath. al Director: After t led in by tha funer. Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, o	fice	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tete)								
in 24 hour ha Funera pletely fille edical (29a. Certifier (Check only one) 1 € Certifying Physical 2 Medical Examiner	an: To the best of my knowl On the basis of examinatio and manner stated.	edge, death occurred et ton end/or investigation, in	ne time, date and place, my opinion, death occurr	and due to the caused at the time, date	e(s) and manner as stated. and place, and due to the cause(s)								
withi To th	29b. Signature and title of certifier	CC	1.	cense number 054424		Date signed (Month, Day, Year) -29-04								
	30. Name end address of person who comp 20E Timonium	leted cause of death (Item 2 rd: Suite	23e) (Type, Print).————————————————————————————————————	inium / N	10 210	93								

Registrar

APR 0 6 2004

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month AFRIL Year 2004 **Physician** 7:45 AM Smith Μ. Jene11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** 1 ☐ M 2 🂢 F Yrs Virginia 80 July 6, Director 230-18-2206 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State I show ral', or items 23a or 28a-f ehow Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Cockeysville Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21030 USA 116 Warren Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Microbiology n/a Technical Engineer 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be of Health and Mental Hitem 27 is marked ot rother treumatic ever Powers Nanie 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sanders J. Smith/Husband 116 Warren Road, Cockeysville, MD 21030 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 4/7/04 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland * 4 □ Donation 5 □ Other (Specify Dulaney Valley Mem. Grdns. 22. Name and Address of Facility 21. Jgn Jun Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Biyan W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE Physician /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760, the attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2X No detached 9 Unknown certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 🕱 No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 No 1 Tyes 2 **X** No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 2 No Certification: To funeral dir this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. the Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours after To the Funerel Dire 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 30263 p 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS 7601 OSLER DRIVE TOWSON MARYLAND 21204 KHOO M. D. 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 03:30 AM **Physician** 2004 Roberta J. Sullivan APRIL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE SAINT AGNES HEALTH CARE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🔀 F 29,1927 New Hampshire 003-12-8953 76 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "naturat", or items 23a or 28a-f show try or other traumatic avent, the Musical Exacting must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 1501 Hilton Avenue 21228 by Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give Year or Date*s*: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Church 12 Religious 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ဂ္ Cornelius Sullivan Maxine Long 19a. Informant's Name/Relationship (Type, Print) (Mother

Mother Catherine Grace Superior) 1501 Hilton Avenue Catonsville, Maryland 21228

Date 20c. Location - City or Town, State Mother Catherine Grace Important: If Iten any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ∕Saints Cemetery A11 4-6-2004 Catonsville, Maryland *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 1889 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland 21228 Dema 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SYNDROME Physician a. ADULT DISTRESS RESPIRATORY 7. DAYS /Medical Due to (or as a consequence of) **Examiner** 0475 INFARCTION ACUTE MYOCARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed LUNG CANCER YGARS METASTATIC Due to (or as a consequence of): physician as Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown YULVAR CARCINOMA Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No GASTROESOFHAGEAL REFLUX DISTASE 2 No certificate THROMBOSIS 1 Yes NEMONZ DEEP 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: or Attending 1 Matural 5 Pending s after dea. 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital o within 24 hours at To the Funeral Di completely filled in Dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier P15640 2004 APRIL, 4 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETERSON AVENUE BALTMARE 900 CATON M MD KICHARLD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 6 2004 Registrar

DHMH 17 Rev 1/2001

ROBERTA

SULLIVAN

ORIGINAL

ORIGINAL

	-	For State Registrar	State	of Marylar		artment of H tificate of I	lealth and M Death		giene Reg. No.	200	+ 10377
8 .		Decedent's Name (First, Middle,	Last)					2. Date of Dea Month	ath Day	Year	3. Time of Death
Physicia		Melvin		SIEGEL				April	1.	2004	12:10 ^{PM}
/Medic Examin	ele:	4a. Facility Name (If not institution,	give street and n			4b. City, Town, or	r Location of Death	•	4c. (County of Deat	h
	g g	Montgomery Villa	ge Rehal	Center	•	Gaither				ntgome	
Funeral		5. Social Security Number	3.Sex 1XM 2 F	7. Age (In yrs.	-	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	v. Year)	Co	hplace (State or Foreign untry)
Director		578-20-5291		79	Yrs.			Nov. 1	5, 19	24 Was	hington, DC
pur M	}	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					10d. Inside City Limits
Aaryli aho	5	Maryland Montgo	mern	Ga	ithers	huro					1 ☐ Yes 2 ☐ No
28e-	Director	10e. Street and Number	incl y		LICITO	10f. Zip Code			10g. Citiz	en of What Co	untry?
with Sa or		20701 Woodfield	Road			20882		I	Unite	d Stat	es
Jeath ris 23	Funeral	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No	- 1	4. Race - Ame	
ING 21213-UU35 be filed within 72 hours after death with the Maryland tal tygiene. id other than "natural", or items 23e or 28e-f show event, the Madical Exerciter months notified at		1 ☐ Never Married 2 🔀 Marrie	Armed I	rorces? ; 2 ∏ No Bive		rres, specify Cuba 1 □ Yes 2 □ X No	an, Mexican, Puerto Specify:	rican, etc.)		Black, White Specify:	
21215-0036 d within 72 hours at giene. er than "natural", or the Modical Exert.	by	3 Widowed 4 Divorced	Year or	Dates: WWI	I	10 163 24,10	ароспу.			Wn	ite
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within 72 and then not the Manie	npi	Elementary/Secondary (0-12)	College	(1-4or 5+)		00 NOT use retired ales	d)		Dog	ıl Esta	to
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	Be	Meyer Sieg					Frieda				
aryland should be and Mental s marked o umatic eve	2	19a. Informant's Name/Relationshi			19b. Mailii	na Address (Street	and Number or Rui		er. City or	Town, State, 2	Zip Code)
Maryis d 2 should th and Mer T is marke treumatic		Velma Siegel, Wi			20701	Woodfiel	Ld Road,	Gaithers	sburg	, MD	20882
C, and teal there there		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of		Date	20c. Lo	cation - City or	Town, State
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item any injury or othe		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		m State	-	natory`or other plac	04/0				50000 ***
IIIII nit. P artme orten injur.		21. Signature of Funeral Service L	-	Kin	ig Davi	d Memoria 2. Name and Addre	al Carden ess of Facility THEBY :	Francos a 1	- Fal	.Is Chu	rch, VA
Balt permit. Depart Import any inj				_		-	Ll St., N				20012
0 T H		23a. Park, Enter the disease, or o shock, or heart failure. List of	complications tha	t caused the dea	th. Do not en	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	, 171	Approximate Interval Between
Physician		Immediate Cause (Final			A	1	4	DISER	C . T.		Onset and Death
/Medical		disease or condition resulting in death)	- M.	o (or as a conse		412214	15/6/	المارية	1,500		
Examiner		Conventiath, list conditions	b Co	3000	STU	5-1-1-3	3504	PAIR	25376		
7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due t	o (or as a conse	quence of):						
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90, e exe iian a urial-		resulting in death) cast	Due	o (or as a conse	quence ot):						
8760, sate be exphysician the buria	dicai	3	d								
OX 6 Certific anding F use as	a a	IF FEMALE:	23c If yes	outcome of pregr	ancy					3d. Date of de	livon
P.O. BOX 6 that the death certifi ed by the attending detached for use as	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	e birth 2 Fet	tal death 3	Ectopic pregnancy	у		-	Month Month	Day Year
O. the de de de de de de de de de de de de de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9Ū Unl		ogaii 5						
that t	by Physician/M	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	inderlying cause giv	ven in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
ds, uires uires signe								1 🗆 '	Yes 20	₹No 3 □ Pi	robably 4 Unknown
I Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed							24a. Was		24b. Were at	utopsy findings available completion of cause of
Rechelled	mc duc								rmed?	death?	completion of cause of
Vital sicien: Trecertificate	a)	25. Was case referred to medical					26. Place of Dea		2) No	10100	22410
Viractie	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DOA Ott	1	ome 5 Resi		S □Other (Spe	cify)
g Phy er thi	n:T	27. Manner of Death	/8.4	te of Injury onth, Day Year)	28b. Time o	of 28c. Inju		28d. Describe			
indin ath. e fun	atio	1 X Natural 5 Pending 2 Accident investig	ation	0.101, Day 1.0a.,	,,	M 1 🗆	Yes 2 □No				
Division of a lor attending Physics death of the physics of the ph	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 200. Fig	ace of Injury - At I	home, farm, st	reet, factory, office		28f. Location (City or To			ural Route Number,
Div		uran saatuutta vaasaa			10,000,000						
Division of Vital Re To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	ledical	29a. Certifier 1 Certifyin	g Physician: To Examiner: On the	the best of my kr a basis of examin	nowledge, dea nation and/or in	th occurred at the ti	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
the hin 24 the F	Medi	one)		anner stated.		29c. Licens	sa number		29d Date	e signed (Mont	th Day Year)
To To	4	29b. Signature and title of teltifier		, \							
L			mx,	MM	- 00:10		005.17	00	4.	-2-2	004.
V		30. Name and address of person of Anushiravan Dad					Terrace,	Cerman	town	MD 20	874
C+	ate	31. Date filed (Month, Day, Year)	a 32	. Registrar's Sign	nafire	8	TCTTGCC,	CEMBII	wii	, 110 20	
Regist		APR 0 6 2004	Sens	The party	D By	souls!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner N lA 1 If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. Months 62.5426 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinary ust be notified at 1 Yes 2 No N BALTIMORE Director MO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ST. or Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 200 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Yes, Give 'ear or Dates: BLACK 3 Widowed 4 Divorced natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) FINANCE POST OFFICE YRS TH GRADE Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be THORNTON HIGGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ Removal from State 09.08.04 ARBUTUS BALTO. MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
VIUGHN C. GREENE FUNERAL 21. Signature of Funeral Service License SERVICE 5151 BAND. NATE PIKE. 18440. MI) 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TUG Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physicien Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, should be 3 Probably 4 Unknown 1 ☐ Yes peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 🗌 Yes 2□ No 2 2 No 1 Tyes of Vital completely filled in by the funeral director, Be 25. Was case referred to medicaf examiner? 26. Place of Death (Check only one, Hospital: 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 ER/Outpatient 3 DOA this 28a. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Mannes of Death 28c. Injury at Work? Certification: To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After I Division 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 2 Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific Eduardo Whreles-Cahadeula MD 0 who completed cause of death (Item 23a) (Type, Print)

State Registrar

Hegistrar APR 0 6 2004

31. Date filed (Month, Day, Year)

ORIGINAL

32. Rigistrar's Signature

		1 - For State Registrar	State of Maryland		irtment of I			ne _{No.} 2001	10379	
Physic		1. Decedent's Name (First, Middle, Last)	TEGGL	62			2, Date of Death	Day Year	3. Time of Death	
/Medi Exami		4a. Facility Name (If not institution, give str Northwest Hospita	reet and number)			or Location of Death		4c. County of Deat	h	
Funeral Director		5. Social Security Number 213-20-2621 Usual Residence of Decedent	7. Age (In yrs. Ii 86	ast birthday) Yrs.	ff Under 1 Year Months Days		8. Date of Birth (Month, Dey, Yes	ear) Co	hplace (State or Foreign ountry) cyland	
Maryland a-f show	tor	10a. State 10b. County Maryland Baltime		, Town or Lo	cation Gwynn Oa	ak			10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
with the	I Director	10e. Street and Number 5806 Windsor Mil	1 Road		10f. Zip Code	21207	10g.	Citizen of What Co USA	puntry?	
If yeal to Zizioooo should be filed within 72 hours after death with the Maryland ad Mental Hygiene marked other than "natural", or Items 23a or 28a-f show matic event, tra Madical Extrainter must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:		Vas Decedent of f Yes, specify Cub I ☐ Yes 2 X No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Bfack, Whit Specify: Wh		
ithin 72 hourship.	Completed t	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give life. L	DO NOT use retire	during most of wor	rking 16b. Kind of Busine		Industry	
ed fa b	Be	17. Father's Name (First, Middle, Last) Milton Borgman	n	HC	omemaker		ne (First, Middle, Mai ise Fauth			
permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or sny injury or other traumatic event. Its Medical Exerting notes.		19a. Informant's Name/Relationship (Typ: Walter Saulsbury To 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	egeler, Sr.	5806 lace of Dispo	Windsor sition (Name of natory or other pla	Mill Road			L207 Town, State	
permit. P. Departme Important sny injury once.		21. Signature of Funeral Specify Dawn F.	Mc Donald	22	Name and Addr Mac Nabb	ess of Facility Funeral H		20,5000 1010	1967-128	
Physician and physician and physician and physician and the burial-transit		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):	APT	eny o) (SCA) E		Approximate Interval Between Onset and Death	
The law requires that the death certificate the has been signed by the attending physpage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnan	су		23d. Date of del Month	livery Day Year	
v requires that been signed b	b	Part II. Other significant conditions cont	ributing to death but not resu		, , ,				o the cause of death? robably 4 DUnknown	
lor Attending Physician: The law requires t after death. Director: After this certificate has been signe i in by the tuneral director, page 2 should be e	Completed	CARoloniyof.	PATHY				24a. Was an autopsy performer 1 Yes 2 2	prior to death?	utopsy findings available completion of cause of	
hysician: his certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	P	ER/Outpatier	II 3LI DOA	ther: 4 Nursing H	ath (Check only one) Iome 5 Residence		ecify)	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Dale of Injury (Month, Day Yeer) 28e. Place of Injury - At ho	28b. Time or Injury	M 1[☐ Yes 2 ☐ No	28d. Describe how 28f. Location (Stree		ural Route Number,	
spital or f nours after neral Direc			building, etc. (Specify ician: To the best of my kno	v) wledge, deat	h occurred at the	time, date and place		se(s) and manner as		
To the Ho within 24 h To the Fu completely	Medical	(Check only 2 Medical Exeminone) 29b. Signature and title of certifier	er: On the basis of examina and manner stated.	tion and/or in		nse number	29d	. Date signed (Mont	th, Dey, Year)	
7)	30. Name and address of person who con	QAYGA6	2000	Print)	Northere	FT Hoxx	wel Co	ul 2004	
S Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	Sport.	2/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 10380 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 27 **Physician** John Robert Thoms LOOK 14:30 M Marz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F 77 Nov 19, 1926 214-20-6523 Director Wisconsin Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MDBaltimore 1♥ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5311 Herring Run Drive 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 144-46 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 K Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) electrician electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Ernst Thoms Franes Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Thoms 5311 Herring Run Drive Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of tuneral Service Licensee ROna I S Wade Enter the disease, or simplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 2-a. Part1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death Immediate cause (Final disease or condition resulting in death) Obstructive Pulmonery Chronic 10 years Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of): Examine

Physician /Medical Examiner

Item 27 is marked other than "natural", or Items 23s or 28s-f show other treumatic svent, the Medical Examinar must be notified at

Health and Mental

permit. Pages 1 and 2 st Department of Health and Importent: If Item 27 is n any injury or other treum

within 72 hours after death with

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit Be Completed by Physician/Medical within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. Certification; To

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

resulting in death) Last	Due to (or as a consequence of): d.			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the und	derlying cause given in Part I.		to use contribute to the cause of death?
			24a. Was an autopsy performed	
25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)	
1 Yes 2 Ho	Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing H	Home 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, streed building, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
29a. Certifier 1 General Ph (Check only one) 2 Medical Exem	ysician: To the best of my knowledge, death ilnar: On the basis of examination and/or inve	occurred at the time, date and place estigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. I	Date signed (Month, Day, Year)

E. University Pokuy Baltinare, Md21218

State Registrar

Medical

Kichard

31. Date filed (Month, Day, Year)

APR 0 6 2004

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

Cook, Jr.

ORIGINAL

DHMH 17 Rev 1/2001

DRI

RKD

			1 = For State Registrar	State of Maryland	-	artment of rtificate of			iene 20 (04 10382				
			1. Decedent's Name (First, Middle, La.	st)				2. Date of Deat		3. Time of Death				
	Physic /Medi		RONALD A- WA	IGGENER				MARCH	30. 200	. M				
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town,	or Location of Dea	th	4c. County of	Death				
			SHOCK TRAUMA CENT				IMORE			NA				
п	Funeral		5. Social Security Number 6. S		ast birthday) Yrs.	If Under 1 Year Months Day			Year)	Birthplace (State or Foreign Country)				
	Director		Usual Residence of Decedent	RUM 2UF 62	113.			10.1-29-	1441	03.30.2004				
	/land		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits				
	Man	tor	MD N	A BAI	TIMO	RE				1 ☑ Yes 2 ☐ No				
	h the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?				
	death with the Maryland ms 23a or 28a-f ahow		CR039	ST.		21;	230		US	A				
	ams ams	Funerai	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No-		American Indian, White, etc.				
36	or It		1 Never Married 2 Married	1 XYes 2 □ No If Yes, Give		1 ☐ Yes 2 💆 N		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify:	11111				
21215-0036	hours after tural; or Ite	ed by	3 Widowed 4 Divorced	Year or Dates:	100 0	d				WHITE				
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72	I within iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		MPLOYE	/		NI	A				
	be filed within 72 hours after death with the Marylan hall Hygiene. diother than "natural", or Itams 23a or 28a-f show event, the Medical Examere must be excitted at	BeC	17. Father's Name (First, Middle, Last)					me (First, Middle, M	Maiden Sumame)					
Maryland	2 should be and Mental Is marked o	To E	WILLIAM WAGE	EVER			MARY	HICKMA	IN					
any	s 1 and 2 should if Health and Men item 27 Is marke other traumatic	,	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Stree	et and Number or F	ural Route Number,	City or Town, St.	ate, Zip Code)				
	and 2		JUDITH WAGGE	SNER	319	14 AV	B. BAL	10. MO.	212	25				
ore	iges 1 nt of Ha i. If iter or oth		20a. Method of Disposition 1 Burial 2 Scremation 3	Removal from State	metery, cren	sition (Name of natory or other pl	ace)	Date 2	20c. Location - Ci	ty or Town, State				
Ë	Pag ment ant:		' 4 ☐ Donation 5 ☐ Other (Specific	GRE	ENMO	JUNT	04-	05.04 E	BALTO.	MD				
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr gacs.		21. Signature of Funeral Service Lice	3	C 22	Name and Add		<u> </u>						
	705 # Q		Varion (1		5 BALR	J. MATC	PIKE, BI	7170 - M	D 21229				
E			shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not ente	er the mode of dy	ring, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death				
	Physician		resulting in death) a. Crushot Vehoclot leduit laylications											
	/Medical Examiner		Tooling in coain)	Due to (or as a consequ	ence of):				•					
		Į.	Sequentially list conditions.	b. — Due to for as a consequ	anca off.									
	nsit	Examiner	in any, leading to initioulate cause. Enter Underlying Cause (Disease or injury	, , , , , , , , , , , , , , , , , , , ,										
ď.	exect n and ial-tra	Exa	that initiated events resulting in death) Last	C Due to (or as a consequ	ence of):									
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	dicai		d										
9	tificat ig phy as th	ed												
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnanc	214		23d. Date of	of delivery				
	ed fo	Physician/Me	in the past 12 months?	4 Pregnant at time of de 9 Unknown		Other (specify)	-y		Month	Day Year				
P.0	that the de led by the a detached i	Phy	9 Unknown					-	-					
	uires tha signed t d be det	by	Part II. Other significant conditions of	ontributing to death but not resul	lting in the ur	iderlying cause g	iven in Part I.		Δ,	ute to the cause of death?				
orc	w requir been si should	ted						1 🗆 Ye	s 2/2/No 3[☐ Probably 4 ☐Unknown				
Records,	e law has b	Completed						24a. Was an autopsy	/ prio	re autopsy findings available ir to completion of cause of				
al F								perform Yes 2		tb? Yes 2□No				
Vital	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital: -V		0	thon	ath (Check only one						
of	Physician: this certific ral director,	-T	1X Yes 2 No 27. Manner of Death	1 L⊴Nnpatient 2 L E	R/Outpatient 28b. Time of	3 DOA		lome 5 ☐ Resider		(Specify)				
NO.	ding After fune	tion	1 Natural 5 Pending	(Month, Day Year)	Injury	28c. Inju Wo	ork? ☐Yes 2☑No	28d. Describe how	w injury occurred	1				
Division	Attend death ctor: A y the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	01001	ne farm stre			28f. Location /Str	eet and Number	or Rural Route Number,				
Ρ	after after Dire	erti	4 Aomicide determined	building, etc. (Specify)	MA	-7		900 Blk	State	- ba Aval				
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1☐ Certifying Ph	ysician: To the best of my know	rledge, death	occurred at the t	ime, date and place	and due to the car	use(s) and manne	er as stated.				
	he Ho n 24 he Fu pletel	Medical	One) (Cneck only One) Medical Exam	iner: On the basis of examination and manner stated.	on and/or inv	estigation, in my	opinion, death occu	irred at the time, da	te and place, and	due to the cause(s)				
	To the trong to th	Σ	29b. Signature and title of certifier	\wedge		29c. Licen	se number	29	d. Date signed (A	Aonth, Day, Year)				
•	Ma		1 Stork	MI)		0.	C.M.E.	M	ARCH 31,	2004				
	7		30. Name and address of person who	completed cause of death (Item	23a) (Type, I			, , , ,						
			JUTTEN LOYE	e My		111 Penr	Street,	Baltimor	e, Maryl	and 21201				
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ıre	South			_					
29	Registr	वा	APR 0 6 200	1 Shows	29	Ann V.	1							

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death	2001	10000
Certificate of Death Reg. No.	2004	10383

	Physic /Medi Exami	cal
	uneral rector	
yland	how	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f eh any injury or other traumatic event, the Medicial Examinat must be notified a once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	. 1	1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea	ath Day	V.	ear	3. Time of	Death
sicia edic		Allison Marg	uerite Wise	ner						APRIL			al	10:25	in M
min		4a. Facility Name (If not institution, go UPPER CHESAPEAKE		TER		4b. City,	Fown, or BEL	Location AIR	of Death		4c. C	ounty of I		10.20	
ral or		215-19-0544	Sex 1 □ M 2KCXF 7. Age (I	ln yrs. last	<i>birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da Feb. 20	y, Year)		Count	ece (State or ry) Land	r Foreign
		Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, To	own or Lo	cation							10	d. Inside Cit	n/ Limite
1011102	Director	Maryland Harfor	1	Bel		cation								1 Yes	
	Fe	10e. Street and Number				10f. Zip	Code				10g. Citize	n of Wha	t Count	ry?	
		1419 Banavie 7	Terrace East				2101	.5				ī	ISA		
	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. V	Vas Deced	ent of Hi	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	- 14	. Race - / Black, V	America		
	F	1 ☐Never Married 2 ☐ Marned	1 ☐ Yes 2 ☐ No If Yes, Give			I□Yes 2	_	Specify:					************		
	d by	3 Widowed 4 Divorced	Year or Dates:				X					Specify: White			
8	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	16	6a. Deced	lent's Usual kind of work	Occupa	ation <i>duri</i> ng mos	t of workin	na	16b. Kind	of Busin	ess/Indi	ustry	
	du	Elementary/Secondary (0-12)	College (1-4or 5+)		life. L	OO NOT us	e retired,)							
	Ö	11			Stu	lent					High	Scho	∞ 1		
	Be	17. Father's Name (First, Middle, Las	it)					18. Mothe	er's Name	(First, Middle,	Maiden Si	umame)			
	ပ္	Michael Bernar	d Wisener					Eli	zabe	th Ann	LaCla	air			
		19a. Informant's Name/Relationship		1	9b. Mailin	g Address	(Street a			l Route Numbe			te, <i>Zip</i> (Code)	
		Michael Wisener	/ Father		1419	Banay	rie :	Terra	ce E	ast, Be	l Air	. ME	21	015	
		20a. Method of Disposition		20b. Place	of Dispos	sition (Nam	e of	1	D	ate	20c. Loca				
.		1 ☐ Buriel 2 ☑ Cremation 3 : 1 ☐ Donation 5 ☐ Other (Specific Specific Sp				ervi			4-7-	04	Towso	n M	larvi	land	
ø	Ì	21. Signature of Funeral Service Lies									101100	11, 1.	CLL y.	Lana	
ouce		harles Is in	neid		13	17 Co	kest	neral	HOM	e, P.A. , Abing	don	MD 3	100	2	
ii),		23a. Part1. Enter the disease, or cor	and caused the	e death. D	o not ente	er the mode	of dying	g, such as	cardiac o	r respiratory ar	rest.	<u> </u>		Approximate	
		shock, or heart failure. List onfi Immediate Cause (Final	y one cause on each line.											interval Betw Onset and D	
an al		disease or condition resulting in death)	a. HD U4,	124											
al er			Due to (or as a c	onsequenc	e of):										
	-	Sequentially list conditions,	b. Due to (or as a co							-					
13-	ju	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequenc	æ or):										
	Examiner	that initiated events resulting in death) Last	cDue to (or as a co	Oneaguang	na of):								-		
ı			Due to (or as a cr	consequenc	o orj.										
	clan/Medical	•	d												
	Me	IF FEMALE:	220 H van automa of a										1		
	lan.	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal dea		Ectopic pre					230	d. Date of Month	,		ear
	Sic	1 Yes 2 No	4□Pregnant at tim 9□Unknown	e of death	5 🗆	Other (spe	cify)							, u ,	,
1	by Physi		and the standard but a			4.11		1. 10. 11		20- Bida					.1.0
	þ	Part II. Other significant conditions	contributing to death but n	ioi resulling	g in the un	derlying ca	use give	in in Paπ I.			/	/		cause of de	
	ted									1 🗆 Y	es 2 1	No 3[] Probal	oly 4 □Ur	iknown
	Completed									24a. Was a	in a	24b. Were	autops	y findings av	vailable
	no.									perfor	med? 2 \Bo	deall)? (as 2	□ No	330 01
ļ	Bec	25. Was case referred to medical						26. Place	of Death	(Check only or					
- 1	To E	examiner? XX Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 🔀 ER/0	Outpatient	3□ DOA	Othe			ne 5 ☐ Reside		Other (5	Specify)		
- 1		27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b	. Time of		c. Injury Work			8d. Describe h			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	tio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigated	1.0		Injury 6	М .	1 🗆 Y	es 2 1	No.	SUNSJACK	1801	HED	50	F	
	fici	3 Suicide 6 □ Could not determined	28e. Place of Injury building, etc. (S	- At home,	farm, stre	et, factory,	office		2	8f. Location (Si City or Town	treet and N	lumber or	Rural I	Route Numbe	Θ <i>Γ</i> ,
	ert	4 ☐ Homicide determined		Specify)					l					H) sctor	
	alc	29a. Certifier 1 ☐ CertifyIng P	hysician: To the best of m	v knowled	ge. death	occurred a	t the time	e, date an	d place, a	nd due to the c	21160(6) 20	d manner	ac etat	ed	
	Medical Certification:	(Check only 2 Medical Exa	miner: On the basis of example and manner stated	amination a	and/or inv	estigation, i	п ту ор	inion, deat	h occurre	d at the time, d	ate and pla	ace, and	due to th	ne cause(s)	
	Me	29b. Signature and little of certifier	. 1			29c.	License	number		2	9d. Date s	igned (Mi	onth, Da	y, Year)	
		Warran A	· Yhilo,				00	CME			APRIL	3,2	004		
7	-	30 Name and address of correct	completed cause of death	h (Item 02) (T:-== 5	Print)									
		30. Name and address of person who	Completed cause of death	n (item 23a	_		~ ~		T	1 # 2	14	1	a o	1201	
CAC		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	<u>+</u>]	.ı ren	in 51	creet	, ва.	ltimore	, Mar	утап	u 2.	LZUI	
Stat stra		APR 0 6 2004		6	9 1	port	21								

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Registrar

		•	For Stete	State of Ma	ryland /		nent of H		and Mer		ene 2001	10384
			Registrar 1. Decedent's Name (First, Middle, Las	st)						Date of Death		3. Time of Death
п	Physicia		Serena	Fave 1	MPL	STPV	_		Δ	Month	OS AN	4 12:10 pm
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	VVCC	4b	City, Town, or	r Location o	f Death	This	4c. County of De	
	LAGITIT	7.	Singi Hospit	al of Bo	altim	ione T	Baiti	mor	e			
	Funeral		5. Social Security Number 6. Se	9X 7. Age	(In yrs. last	Mo	Under 1 Year onths Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,	Year) (irthplace (State or Foreign Country)
	Director		236-45-6411	□ M 2 % '	_5	Yrs.			De	ec. 31,	1998 Wes	st Virginia
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Location	n					10d. Inside City Limits
	Mary 1 sh	ţō	Maryland Baltimor	~	Bal+	imore						1 ☐ Yes 2X No
	r 28e	Director	10e. Street and Number		Durc.		0f. Zip Code			10	g. Citizen of What	Country?
	th with	a D	601 Goodman Avenu	ie			21222				USA	
	ems ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was	Decedent of H	lispanic Orig	jin? (Specify , Puerto Rica	Yes or No-	14. Race - An Black, Wh	nerican Indian, nite, etc.
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 📉No If Yes, Give	0	10	Yes 2XNo	Specify:			Specify:	-7 ° 1
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than *naturel; or flems 23a or 28e-f show ent, the Medical Examinar must be notified at	q pe	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16	6a. Decedent'	s Heual Occur	ation		1	6b. Kind of Busines	Vhite
Ϋ́.	in 72 n • na	Completed	(Specify only highest gra-	de completed)		(Give kind	of work done of IOT use retired	durina most	of working		ob. Talle of Desirios	a madaly
25	filed withi Hygiene. other thar ent, the W	шо	Elementary/Secondary (0-12)	College (1-4or 5+	+)	De	ependen	it			Not Self	Sufficient
	e file at Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name <i>(Fi</i>	rst, Middle, M	aiden Sumame)	
Maryland	shoutd be ind Mental marked o umatic eve	2	Michael Patri	.ck Web	ster_			Kimb	erly	Sue	. Jone	es
Jar	s m s m		19a. Informant's Name/Relationship (7			-					City or Town, State	
	1 and 2 Health tem 27 i		Michael P. Webste	er – Father		601 GOO e of Disposition		venue	, Balt		Maryland Oc. Location - City of	
altimore,	Pages nent of I ont: If its iry or o		1 K Burial /2 □ Cremation 3 □	Removal from State	ceme	etery, cremato	ry or other plac		4/08/0)4	•	
를	permit. Pag Department Importent: I any injury o		*4 □ Donation 5/□ Other (Specify 21. Signal 11 15 □ ral Service Lion		Dula	ney Va	Lley Me me and Addre	m. Gd: ss of Facility			inonium,	
Ba	permit. Departr Importe any inje		D / HA 9/ 9	100					PICCO		neral Hon	re, P.A. Tyland 21014
			23a. Part L. Entertine disease, or compensation, or heart failure. List only	plications that caused to	the death. D			_				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	note	otati	- 2	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		aus.	ona		Onset and Death
	/Medical		resulting in death)	a. / Pour to /occord			~~	x - 0	~~~			
				Due to (or as a	consequent	ce of):		7				1
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		niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a				7				
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760,		cal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or as a	consequenc	ce of):						
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			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H			iene 20	04	10385
	Physici /Medic		1. Decedent's Name (First, Middle, Las UAMES L, U	villiams	Se.			2. Date of Death	Day	Yeer DOA-	3. Time of Death 2'.25 pm
	Examir		4e. Fecility Name (If not institution, give	street and number)		1	Location of Death	1	4c. County o	f Deeth	
	<u> </u>		North Arundel He		a day a land birth d	Glen Bu	urnie If Under 24 Hrs.	10.0	Anne		
	Funeral Director			M 2□F 7. A9	e (In yrs. last birthday) 67 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Dey, 8-18-19	Year)	9. Birthpl Count	ace (State or Foreign try)
	pu ,		Usuel Residence of Decedent		140.00						
	show	ŏ	MD Anne Arus	nde1	Glen Bu					10	0d. Inside City Limits 1 ☐ Yes X☐ No
	the A	Director	10e. Street and Number		GICH Bul	10f. Zip Code		10	og. Citizen of Wi	hat Count	
	h with	D	7213 Crown Road	i		21060)			USA	•
	ems sermin	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi tf Yes, specify Cuba	ispanic Origin? (Sr	pecify Yes or No-	14. Race		an Indian,
36	72 hours after death with the Maryland "naturel", or items 23a or 28e-f show sdicul Examinat must be notified at	by Fu	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 I If Yes, Give	No	1 ☐ Yes 2X No	Specify:	7 110411, 010.7	Specify:	wh:	
00-	2 hour	led b	15. Decedent's Edi	Year or Dates:	16a. Dece	dent's Usual Occupa	ation	1	6b. Kind of Bus		
215	.E .E	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed) Cotlege (1-4or 5	(Give	kind of work done of DO NOT use retired	during most of world	king			,
21	77 70 2	Con		4		Chemist			'ertiliz		ompany ———
Maryland 21215-0036	o g g o	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, M			
IZ	s 1 and 2 should by the strength of the streng	T ₀	Troy Leonard Wil		19b. Maili	ng Address (Street a		livia Mee			Code)
	1 and 2: Health ar tem 27 is		Mrs Betty Joe Will	liams/wife		Crown Rd.				,	
ore,	iges 1 a nt of Hear If item or othe		20a. Method of Disposition 1 X Burial 2 Cremation 3	Damarral from Chat-	20b. Place of Dispo			-	0c. Location - C	ity or Tov	vn, State
ij	Pages ment of tent: If it		'4 □Donation 5 □Other (Specify,		Cedar Hil			/2004 B1			
Baltimore,	permit. Pag Department Importent: I eny injury o		21. Signature of Funerat Service Licens	11	364	2. Name and Address Second Av	e SW, G1	ngleton I en Burnie	Funeral e MD 210	Home 061)
9			23a. Part1. Enter the disease, or comp shock, or heart failure. List only compared to the comp	lications that caused ne cause on each lin	I the death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arres	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Intrac	exebra b	موم					Onset and Death
ð	/Medical Examiner		Testing in dealing	Due to (or as	a consequence of):						
	10 3	Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):						-
	cuted nd ransit	Examin	that initiated events	c							
30,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	a consequence of):						
38760,	physic	dical		d				· · · · · · · · · · · · · · · · · · ·			
Box (deati certific e attending p ed for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date	of deliver	v
	o it at	Physician/M	in the past 12 months?	1 □ Live birth 4 □ Pregnant at 9 □ Unknown		Ectopic pregnancy Other (specify)			Month	n	Day Year
P.0	that the de led by the a detached f	Phy	9 Unknown								
Records,	v requires that been signed b should be deta	ted by	Part II. Other significant conditions co	minuting to death bi	ut not resulting in the u	nderrying cause give	in in Parti.				bly 4 Unknown
Reco	elaw hasb	ompleted						24a. Was an autopsy performe	ed? prid	or to com- ath?	sy findings available pletion of cause of
Vital	iysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?			W7		h (Check only one)		-	
of\	Physicien: this certific al director,	To	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatie			4 □ Nursing ⊓o	me 5 Residen			
OU	ding h. After funer	tion	1 Naturel 5 Pending	28a. Date of trijui (Month, Da)	Yeer) 28b. Time of Injury	Work	at ? ′es 2 □ No	28d. Describe how	v injury occurred		
Division	l or Attending after death. Director: After in by the fune	ifica	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ury - At home, farm, str			28f. Location (Stre	et and Number	or Rural I	Route Number,
ä	rs after al Dire ed in b	Certification:	4 Homicide	building, etc	с. (Specify)			City or Town,	State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medicat Exami	sician: To the best of ner: On the basis of and manner sta		estigation, in my op	inion, death occur	red at the time, date	e and place, and	er as stat d due to t	ted. he cause(s)
	To t To tl comp	Ň	29b. Signature and title of certifier	11.	/ 000	29c. License	number	290	d. Date signed (* '
	4		> Sutin -	Janos	a mo	ال	12405	a	pril 2.	, SO	CA-
	\			10 305	eath (tem 23a) (Type, Waspital	Print) Consolous	len Burni	e, MD	2106/		
	Sta Registr		APR 6 Day, 2004	32. Registra	ar's Signatur	back			,		

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For State Registrar	State of Maryland		rtment tificate			Re	g. No. 20	04 103	387
and the same	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last) COOCE 4a. Facility Name (fi not institution, give s	original street and number)	onb	4b. City, T	Town, or Lo	cation of Death	2. Date of Death Month	-	3. Time of D	Death
	Funeral Director		5. Social Security Number 6. Sex 57 7 - 56 - 826 19	M 20 F 79	Yrs.			Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar 17,	Year) 1925	9. Birthplece (State or Country)	Foreign 1k
	the Maryland 28a-f show	ector	10a. State 10b. County Carroll		ykesv		Codo		140	g. Citizen of Wh	10d. Inside City	
	3a or	i Dir	7309 2nd Avenue			101. 210		21784	10	US	,	
036	filed within 72 hours after death with the Maryland Hygiene. other than 'natural', or Items 23a or 28a-f show ent, the Medical Exempler must be invilled at	by Funeral Director	11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	nk	Vas Decede Yes, specif		anic Origin? (Si Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	Black,	American Indian, White, etc.	
21215-0036	within 72 ho ane. than "natur ie Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) unk		16a. Deced (Give I life. D	ent's Usual kind of work OO NOT use	done duri	n ng most of won	unk 1	6b. Kind of Busi	iness/industry	unk
Maryland 2	2 should be filed and Mental Hygi Is marked other aumatic event,	To Be Co	17. Father's Name (First, Middle, Last)			un	k 18	. Mother's Nam	ne (First, Middle, Ma	aiden Sumame))	unk
Baltimore, Mary	Pages 1 and nent of Health ant: If item 27 ury or other tr		19a. Informant's Name/Relationship (Ty) Northwest Hospita] 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R '4 □ Donation 5 ☑ Other (Specify)	emoval from State 20b. Plac	5401 ce of Dispos netery, crem	01d C sition (Name atory or oth	Court e of her place)	Road R	andallstor Date 20	wn, MD	- 1 - 1	
Ba	permit. Deperti		21. Signature of suneral service License Ronald S	ations that caused the death.	St. Ba.	Ltimo:	natom re, M	y Board D 2120	1		ore Street Approximate	
8760,	Physician //Medical Examiner points it is pring it is	Icai Examiner	shock, or heart failure. List only on Immediath Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	nce of):	1			SITE	5	Interval Batwe Onset and De	eath
P.O. Box 68	Attending Physician: The law requires that the death certificate be executed closh. Geath. sctor: Atter this certificate has been signed by the attending physician and y the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 🗍	Ectopic pre Other (spe				23d. Date of Month		ar
	quires that in signed by uld be deta		Part II. Other significant conditions con	LIVER, I				n Part I. ELLI TUS		_	ute to the cause of dea	
Division of Vital Records,	: The law requir cate has been si page 2 should	Completed by	REMAZ INSUPF	niewcy.					24a. Was an autopsy performe	ed? prid	ere autopsy findings av or to completion of cau ath? Yes 2 \(\text{No}\)	ailable ise of
Ĭ;	sician certifi rector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	2/0-4	aC 2004	0.4		h (Check only one)			-
ion of	To the Hospitel or Attending Physician: The I within 24 within 24 burns after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	ation; To	27. Manner of Death 1 Autural 5 Pending 2 Accident investigation	1	VOutpatient Bb. Time of Injury		c. Injury at Work?	4 □ Nursing Ho	ome 5 Resident 28d. Describe how			
Divi	To the Hospitel or Attence within 24 hours after death To the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)					City or Town,	State)	or Rural Route Numbe	er,
	• Hosy 24 ho • Fune etely fi	Medical	29a. Certifier (Check only one) Certifying Phys 2 Medical Examin	sicien: To the best of my knowle ter: On the basis of examination and manner stated.	edge, death n and/or inve	estigation, i	n my opinio	on, death occur	red at the time, date	e and place, and	d due to the cause(s)	
)	To th within To th comp	Me	29b. Signatur, and title of certifier	mymo		29c.	DS4	288	290	I. Date signed (I	Month, Pay, Year) 26 H2014	ţ
			30 Name and address of person who so RAM ASWAY T RAMAS (Month, Day, Year)	mpleted cause of death (Item 2: AM, ARAPW) 32. Registrar's Signatur	-			ist n	GOIGAL	CENTE	~	
	Sta Registr		ADD 0 6 2004		B	Spar	Kart					

DAP		artment of Health and Mental I	Hygiene Reg. No. 2004 10388
Physician	Decedent's Name (First, Middle, Last) Allen Williams	2. Date of Month MARC	
/Medical Examiner	4a. Facility Name (If not institution, give street and number) MARYLAND GENERAL HOSPITAL	4b. City, Town, or Location of Death BALTIMORE CITY	4c. County of Death
Funeral Director	5. Social Security Number unk 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday), 48 Vrs. Usual Residence of Decedent 10a. State 10b. County 7. Age (In yrs. last birthday), 48 Vrs. 10c. City, Town or Li	Months Days Hours Min. (Month Aug 1	16 Birth J. Day, Year) 10 , 1955 9. Birthplace (State or Foreign Unk Unk Unk Unk Unk Unk Unk Unk Unk Un
uter death with the Mary uter death with the Mary in terma 23a or 28a-f sh inst must be notified. Funeral Director	10e. Street and Number 1301 W. Madison Avenue #D	timore 10f. Zip Code 21217 Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	ty Yes 2 □ No 10g. Citizen of What Country? USA or No- 14. Race - American Indian, Bleck, White, etc.
ILL 13-0030 filed within 72 hours a Hygiene. ther than "natural", o nt. the Medical Exar on. Completed by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk Unk	1 Yes 2 No Specify: Ident's Usual Occupation skind of work done during most of working DO NOT use retired) Unk 18. Mother's Name (First, Milester)	Specify: black nk 16b. Kind of Business/Industry unk ddle, Maiden Sumame) unk
re, Maryiarra is and 2 should be file Health and Mental Hy tem 27 is marked oth tother traumatic even To Be	19a. Informant's Name/Relationship (Type, Print) O.C.M.E. 111 20a. Method of Disposition 20b. Place of Dispo	ing Address (Street and Number or Rural Route Note Penn Street Baltimore position (Name of Date	umber, City or Town, State, Zip Code)
permit. Peges Department of himportant: If Ite any injury or of once.	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in State 21. Signature of Euneral Service Licensee Ronal Ld S, Wad, Director	2. Name and Address of Facility tate Anatomy Board 655 altimore, MD 21201	W. Baltimore Street
w requires that the death certificate be executed w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the buriat-transit applications the participation of the control of the c	Sequentially list conditions, if any, leading to immediate Cause (Disasse or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	^	ny arrest, Approximate Interval Batween Onset and Death
the death certific the death certific by the attending packed for use as ached for use as hystician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
The Corids, P.O. BOX 00/ The law requires that the death certificate the has been signed by the attending physage 2 should be detached for use as the completed by Physician/Medic.	Part II, Other significant conditions contributing to death but not resulting in the u	24a. V	Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Munknown Was an utopsy sindings available prior to completion of cause of death?
ding Physician: 3. After this certifica funeral director, g	25. Was case referred to medical examiner? **EXYes 2 \sum No 27. Manner of Death 1 \sum Natural 5 \sum Pending 2 \sum Nostigation 2 \sum Accident investigation 2 \sum Strington 1 \sum Could not be	26. Place of Death (Check on the strength of t	as 2 No 1 Yes 2 No nlv one) Residence 6 Other (Specify) ibe how injury occurred
To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the the	4 Homicide determined 2ee. Prace of injury. At nome, farm, still building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	City or	on (Street and Number or Rural Route Number, Town, State) the cause(s) and manner as stated.
To the Hosp within 24 hou To the Fune completely fi	(Check only as Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier M. D. 20 Nema and address of acceptable completed accept of death (Nem. 32a) Trans	29c. License number OCME	29d. Date signed (Month, Day, Year) MARCH 10, 2004
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, L(NG L , M (D 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature	11 Penn Street, Baltimo	ore, Maryland 21201

		1 - For State Registrar		,, ,				Death		ntal Hygier Reg. I Date of Death	No. 20	-	038
Physicia		Decedent's Name (First, Middle, I MARY A. WHITT)								Month I	Day Y 4 200	ear	2:00 I
/Medic		4a. Facility Name (If not institution, g		mber)		4b. City	Town, or	Location of			4c. County of	Death	
_Admi		BRIGHTWOOD CENT	ER					ANDVIL			BALTI		
Funeral Director		216-18-9232	Sex 1□M 2XQF	7. Age (In yrs. I 81	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day, Ye 10/18/22	er) g	. Birthplace (S Country) MARYLAN	tate or Ford
show	_	Usual Residence of Decedent 10a. State 10b. County	IMORE	10c. City	, Town or Lo		KVILI						de City Lin
28a-f	Director	MD BAL'I	INORE				p Code	<u> </u>		10g.	Citizen of Wh		- 11
a o	<u>a</u>	8338 EDGEDALE F	OAD.				212	34			US	Δ	
TB 2.	era	11. Marital Status	12. Was Dece	edent Ever in U.	S. 13.	Was Dece			in? (Specify	y Yes or No- an, etc.)	14. Race -	American India	an,
of Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-1 show or other treumatic event, the Medical Examinar must be ricillized at	Completed by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed For 1 ☐ Yes tf Yes, Giv Year or D	2 No		rres,spe 1 ☐ Yes		Specify:	Puerto Nic	ап, өкс.)	Specify:	White, etc. WHITE	:
n natur Medical	pleted	15. Decedent's (Specify only highest to Elementary/Secondary (0-12)	Education grade completed)	1-4or 5+\	16a. Dece (Give life.	dent's Usu kind of w DO NOT L	ial Occupa ork done d ise retired	ation luring most o	of working	16b	, Kind of Busi	ness/Industry	
r then	E O	6th GRADE	College (1-401 3+1	HOME	EMAKE	R				HOM	E	
Mental Hygie arked other atic event, II	To Be C	17. Father's Name (First, Middle, La	st) BINSON							irst, Middle, Maid H HOLTHA			
th and M		19a. Informant's Name/Relationship		ICPAND		-		and Number		oute Number, Cit		ate, Zip Code)	
Heal tem 2 other		JOSEPH WHITTIE, 20a. Method of Disposition	SK. / III	JSBAND 20b. P	lace of Dispo emetery, crer	sition (Na	me of		Date			ty or Town, Sta	ate
y or o		1 ☑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe		State	JANEY V				+/7/04	4 co	CKEYSV.	ILLE, M	ID
Department of Health a Importent: If Item 27 is any njury or other tre sncs.		21. Signature of Funeral Service Lie		// }				s of Facility	THE	JOHNSON TOWSO	FUNER	AL HOME	P.A
hysician /Medical		23a and Enter the disease, or co shock, or heart faiture. List or Immediate Cause (Final disease or condition resutting in death)	_ a	cals the death each line.	nd Do not ent	er the mo	de of dyin	g, such as co	ardiac or re	espiratory arrest,		Appro	ximate al Betwee land Dea Much
ician and purial-transit	Examiner	f any, leading list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequence of a consequence of a									
attending phys	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 moonts? 1 □ Yes 2 ₹ ₹ No	d	tcome of pregna	incy	∃Ectopic p	pregnancy				23d. Date of Month		Yea
igned by the be detached	Phys	9 Unknown Part tt. Other significant condition			ulting in the u	nderlying	cause divi	en in Part I		23e. Did tobacc	co use contrib	ute to the caus	e of deat
been signed by the should be detached	þ	Part II. Other significant condition	s contributing to u	Ball Dut not 163	utting in the d	Tradity ing	Cause givi	911 111 1 1211 1.		1 Tes		Probably	
ate has b	Completed									24a. Was an autopsy performed 1 Yes 2 2	prio	ere autopsy find or to completion ath?] Yes 2 2 No	n of caus
is certificate director, pag	Be	25. Was case referred to medical examiner?	Hearital				Oth			Check only one)			
this aldii	2	1 ☐ Yes 2 💢 No 27. Manner of Death		tnpatient 2 of Injury	ER/Outpatier 28b. Time o			4 IV Nur		5 Residence			
r death. ector: Alter by the funera	Certification:	1 Natural 5 Pending 2 -Accident investiga	tion	of Injury oth, Day Yeer)	Injury	М		yat k? Yes 2□N	lo				
: E E	Certifle	3 Suicide 6 Could no 4 Homicide determin	art 208. Flact	e of Injury - At he ling, etc. (Specif	ome, farm, str	reet, facto	ry, office		28f	Location (Street City or Town, St	t and Number tate)	or Hural Houte	Number,
4 hours	ledical	29a. Certifier 1 Certifying (Check only one) 1 Medicat E	Physician: To the aniner: On the b and man	e best of my kno pasis of examina iner stated.	wledge, deat ition and/or in	vestigatio	n, in my o	pinion, death	occurred	at the time, date	and place, an	ner as stated. d due to the ca	use(s)
1 5 5 E	ž	29b. Signature and title of certifier	1	11.0		29	c. Licens	e number	7.6	29d.	Date signed (Month, Dey, Yo	ear)
within 2 To the)	/	MI			P	11-	16 /		415	16 8	

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2004
•	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) ANNIE WITHER SPOON 4b. City, Town, or Location of Death 4c. County of Deeth
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months 1 Days Hours Min. Why 1 June 1937 9. Birthplace (State or Foreign Country) Usual Residence of Decedent
	within 72 hours after death with the Maryland with 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28e-f show he Mudicul Exertings must be notified at	Director	10a. State 10b. County 10c. City, Town or Location 10d. finside City Limits MD BATO. LUTTER VILLE 1□Yes 2☑No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
FUNIE	urs after death w al', or Iteme 23a Exactinar must I	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married 1 Pes 2 No Specify: 1 Pes 2 No Specify: 1 Pes 2 No Specify: 1 Pes 2 No Specify: 1 Pes 2 No Specify: 1 Pes 2 No Specify:
715	led within 72 ho tygiene. her than "naturi	Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Example 17. Example 18. Kind of Business/Industry 18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
5700	12 should be fill and Mental H le marked out reumatic even	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ANNIE CONVERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117
Witherspoon	perfullioricy, Ividity identity in English 2. 12. 13. 13. 13. 13. 13. 13. 13. 13. 13. 13		SARA CYOLUELL - SISTEY 930 GFF/ILL DT. OCUINGS MLLS MD, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. CARMEL 4-6-04 BAITO, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
	Physician		23. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition a. Athero Scurotic Cardia Vascular Approximate Interval Between Onset and Death Approximate Cardia Vascular
68760		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
O Box 6	To the Hospitel or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
Division of Vital Records P.O. Box	w requires that s been signed b	leted by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Junknown 24a. Was an 24b. Were autopsy findings available
Vital Re	yeicien: The lav is certificate has director, page 2:	To Be Comp	autopsy performed? prior to completion of cause of death? 1 Yes 2 No No No No No No N
vision of	Attending Phyer death.	ification: T	27. Mann of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined determined. 28a. Date of Injury 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28b. Date of Injury At home, farm, street, factory, office 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred
ć	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: Alter completely filled in by the funeral	Medical Certification:	29a. Certifier (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within To the comple	Me	29b. Signature and title of certifier AD 29c. License number 29d. Date signed (Month, Dey, Year) 4/3/04
ı	Sta		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sonia Yousut, ND Go Mary land General Hospital 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature
0	Registi DHMH 17 Rev 1/2		APR 0 6 2004 ORIGINAL

		ı	For State Registrar	State of	Marylan	•	artment of	Health and Death	l Mental H	ygiene Reg. No.	2004	10391
	Physicia		1. Decedent's Name (First, Midd Audrey Lee Wal						2. Date of I Month MARC	Day	1 MOC4	3. Time of Death 9:45 AM
	/Medic Examin	100	4a. Fecility Name (If not institution	n, give street and nun			~	or Location of De	ath		County of Death	
			ST AGNES 5. Social Security Number	EALTHC F	7. Age (In yrs.	last hirthday)	If Under 1 Year	LTIMO		Birth	N/A	lace (State or Foreign
	Funeral Director		220-34-6244	1 □ M 2 X F	65	Yrs.	Months Days		n. (Month,	Day, Year) 9, 193	Coun	land
	and		Usual Residence of Decedent 10a. State 10b. County	/	10c. Cit	y, Town or Lo	ocation				11	Od. Inside City Limits
	Maryl.	tor	MD Ba	ltimore			Lansd	owne				1 Tyes 2 No
	or 28a	Director	10e. Street and Number	T C T III C T C			10f. Zip Code		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	10g. Citiz	en of What Coun	try?
	s 23a	erall	624 Washington		dent Ever in U.	S 12 1		21227	(Specify Vos or I		ted Stat	
"	ifter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	rried Armed For	rces? 2∕⊡No			Hispanic Origin? ban, Mexican, Pu	erto Rican, etc.)		Black, White,	etc.
21215-0036	urel', o	þ	3 Widowed 4 Divorce		e ites:		1 ☐ Yes 2 💢 No				Specify: Whi	
15-(in 72 h	Completed	(Specify only highe	nt's Education est grade completed)		16a. Dece (Give lite.	dent's Usual Occu kind of work done DO NOT use retire	ipation e during most of и ed)	vorking	16b. Kin	d of Business/Inc	dustry
212	d with giene. or the	Som	Elementary/Secondary (0-12)	College (1	-4or 5+)		Cashier				Grocery	,
pu	be file	Be	17. Father's Name (First, Middle,						_{lame (First, Midd} a Virgir		,	
2	should nd Mer mark matic	To	Julius Carroll 19a. Informant's Name/Relation			19b. Mailir	ng Address (Stree	t and Number or				Code)
Baltimore. Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Imprortant: if item 27 is marked other then "netural", or farms 23e or 28e-f show any injury or other treumatic event, the Wedical Examinatorism the notified at 90ce.		Andrew G. Walt	her III l	lusband	-		ton Ave.	, Lansdo	owne, l	MD 21227	
ore	ges 1 f of He if iten or oth		20a. Method of Disposition 1 DBurial 2 Coremation	3 □Removal from S			sition (Name of matory or other pla		Date		ation - City or To	
Itim	nit. Pa artmen ortant: injury in.		4 □ Denation 5 □ Other (3	2	Вауч			, Inc. 4			timore,	MD Lansdowne
Ba	Deport Impo		COCHUM	DHI	LEATE	1 2 01		onds Fer				
			23a. Part1. Enter the disease, or shock, or heart failure. Lis	t only one cause on e	ach line.			_		arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ERCA!		RESPIRAT	ory fai	LHURE			2 DAYS
	Examiner						VE PULMO	21 LYSHAM	BASE EX	WER	BATION 3	L DAYS
	Do iii	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a conseq							
W.	be executed sicien and burial-transit	Examlner	that initiated events resulting in death) Last	c	or as a conseq	uence of):						
2 8760	ate be ex nysicien he buria	calE		d								
11/ 0	ertifica ling ph		IF FEMALE:	222 16						Fig.		
THE NO.	leath certifica attending pt I for use as ti	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?		irth 2 ∏Feta ant at time of d	Ideath 3□	Ectopic pregnant Other (specify)	су		23	d. Date of delive Month	ry Day Year
70	at the d by the stached	hysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unkno								
-	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	þ	Part II. Other significant condit 1464 SMALL			ulting in the u	_	iven in Part I.		d tobacco us ☐ Yes 2 ☐		e cause of death?
0	w require been si should b	letec				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			24a. Wt		24h Were autor	osy findings available
	The law cate has page 2.	Completed							- au	topsy rformed?	prior to con death?	npletion of cause of 2 No
DR		Be C	25. Was case referred to medica examiner?						eath (Check only			
3 5	Phys this ral di	٠ <u>.</u>	1 Yes 2 No	28a. Date o	of Injury	ER/Outpatier	IL 3LI DOA		Home 5 ☐ Re			')
A	nding l ath. r: After e funer	atlon	1 Natural 5 ☐ Pendi	/A font	h, Day Year)	Injury	W	ork?]Yes 2 □No				
A	or Attenation description of the Director: in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 286. Place	of Injury - At ho	ome, farm, str	eet, factory, office			(Street and own, State)	Number or Rural	Route Number,
×	To the Hospitel or Attending within 24 hours after death. To the Funarel Director: After completely filled in by the fune.		29a. Certifier	ng Physician: To the	best of my kno	wiedge, deati	n occurred at the t	ime, date and pla	ce, and due to th	ne cause(s) a	nd manner as sta	ated.
	To the Hospitel within 24 hours and to the Funerel completely filled	edical	(Check only 2 Medica one)	Examiner: On the ba	asis of examina ner stated.	tion and/or in	vestigation, in my	opinion, death oc	curred at the time	e, date and p	place, and due to	the cause(s)
	Mithi To th	Ž	29b. Signature and title of cedifi	er 1.	Á			se number	0		signed (Month, L	
	V		30. Name and address of person	who completed asses	a of death (Item	23a) /Tune	Print)	0601	05	MIHK	14 31	2004
	"\		KARL QUIST -	THERSON		500	CATON	0601 1 AVEN	ME B	ALTI	mare,	MD.
	Sta Registr		31. Date filed (Month, Day, Year APR 0 6		egistrar's Signa		Some?				,	

			For	State of Maryla	and / Depa	artment of H	lealth and M		_	Die.	
			1 - State Registrar		Ce	rtificate of l	Death		-	104	1039
п	Physici	an	Decedent's Name (First, Middle, Last)					Date of Death Month	Day	Year	3. Time of Death
	/Media	cal	Dorothy Jane Wine					March		004	7:00 P M
	Examir	ier	4a. Facility Name (If not institution, give st 33 First Avenue	treet and number)			Location of Death		4c. County		
	Eupovol		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year	downe	8. Date of Birth		altin	
	Funeral Director			M 2XIF 8		Months Days	Hours Min.	(Month, Day, 1 June 28,	^(ear)		lece (State or Foreign stry)
	D		Usual Residence of Decedent			1		,			
	show	7	10a. State 10b. County		City, Town or Lo	ocation				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ne M	ecto	MD Baltimo	re		Lansdown	e	10.			
	with with	ā	33 First Avenue			10f. Zip Code 212	27		g. Citizen of V United		•
	hours after death with the Maryland tural', or Itams 23a or 28a-f show al Examinarin wit be notified at	Funeral Director		2. Was Decedent Ever in	U.S. 13.		ispanic Origin? (Spe n, Mexican, Puerto F			e - Americ	
9	or Ita		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ZNo				Rican, etc.)		k, White,	
93	iral', c	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify	· Wh	ite
Maryland 21215-0036	"natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Occupa kind of work done of	ation during most of workin)	ng 16	Bb. Kind of Bu	siness/Inc	lustry
12	within 72 ene. than "nai	ш	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	Homemake			0	wn Ho	nm o
0	filed Hygi other ent,	CO	17. Father's Name (First, Middle, Last)			Homemake	18. Mother's Name	(First, Middle, Ma			iiie
<u>a</u>	lid be lental rked o	To Be	Osbourne MacLeod				Edith	Elizabet	th Abb	οV	
ary	should and Men	_	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailir	ng Address (Street a	and Number or Rura				Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or itams 23e or 28e-f show other traumatic event, the Medical Exercities in a libe notified at		John O. Wineke So	n	2626	Jonathan 1	Road, Ell:	icott Ci	ty, MD	2104	2
Baltimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b emoval from State M	Place of Dispo	sition (Name of patory or other place 1ge Memor:	D:	ate 20	c. Location -	City or To	wn, State
Ē	permit. Pages Department of I Important: If It any injury or o		Donation 5 Other (Specify)			Da-	r_{l} $4-2-4$		lkridge		
ga	permit. Departr Imports sny inj		21. Signal (A.S. Funeral Service Chanse	Which							Lansdowne
			23a, Part1, Enter the disease, or complic	cations that caused the de			nds Ferry			≥, MD	ZIZZ/ Approximate
- 6	Dhysisian		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.	1. 1.		1		•		Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Due to/(or as a cons	equence of):	THON	Mort			7	mmed rate
	Examiner			/	,						
	D #	Iner	Sequentially fist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					-	
	and -trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a cons	oguadaa of):						
/60,	eath certificate be executed attending physician and for use as the burial-transit	cai E		Due to (or as a cons	equence oi).						
68/	phys s the		d.								
Box	The law requires that the death certifica tte has been signed by the attending ph age 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of prec					23d. Date	of deliver	rv ·
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fe		Ectopic pregnancy Other (specify)			Mor		Day Year
J.	at the by th tache	hys	9 🗆 Unknown	9□ Unknown							
	w requires that the de been signed by the should be detached	by F	Part II. Other significant conditions conti	tributing to death but not r	esulting in the u	nderlying cause give	n in Part I.		·		e cause of death?
00	een s	ted						1 Tes	\$\ØNo	3 Proba	ably 4 Unknown
Hecords,	has b	ompleted						24a. Was an autopsy	p	rior to com	sy findings available appletion of cause of
	(a) CT	O						performe 1 ☐ Yes 2 ☐		eath?	212 No
Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 3 ☑ No	ospital:		Othe	26. Place of Death				
ō	y Phys ar this eral di	}-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of	28c. Injury	at 2	e 5⊠ Residenc 3d. Describe how)
<u>o</u>	nding ath. r: Afte e fun	atio	1/XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work M 1 □ Y	? ′es 2 □ No				
DIVISION	r Atte er de: recto by th	ertification	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre	eet, factory, office	21	Bf. Location (Stree City or Town, S	t and Numbe	r or Rural	Route Number,
5	ital o	Cer		1			J.				
	To the Hospital or Attending Pl within 24 hours atter death. To the Funeral Director: After the completely filled in by the funeral	edical	(Check only 2 Medical Exemine	cian: To the best of my ker: On the basis of exami	nowledge, death nation and/or inv	occurred at the time restigation, in my op	e, date and place, ar inion, death occurre	nd due to the caus d at the time, date	e(s) and mar	ner as sta	ited. the cause(s)
	thin 2 thin 2 or the	Med	one) 29b. Signature and title of dertifier	and manner stated.		29c. License			Date signed		
	F ≯ F 8		Part C	1.11:4	J.D	177	7365	3	/31/	4	-//
	0,		30. Name and address of person who com	ppleted cause of death (It	em 23a) (Type	Print) I	0.43	1 3/	01/(11.	
	\		Patrice W.	white 40	05 Fre	forth &	J. H Zai	z Bal	Lover	, 1	1021228
	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature			1	4.		
	Registr	ar	APR 0 6 2004	1 mention	1.1	8					

			State of Mandan	d / Department of Health and N	Montal Hygiana	
		1 State	State of Marylan	Certificate of Death	(1)	Ul 10303
	_	Registrar	-41	Certificate of Death	Reg. No.	3. Time of Death
Phy	sician	1. Decedent's Name (First, Middle, La.		in a and		2 00A M
/M	edical	LORRHINE		20 and 4b. City, Jawn, or Location of Death		
Exa	miner	4a. Fecility Name (If not institution, give	peake Med-	ALL CONTROL COLUMN OF LOCALITY OF DEALITY	HARI	TOPA
	26,		ex 7. Age (In yrs.	last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) 9.	Birthplace (State or Foreign Country)
Fune Direc		217 24 2284	□M 200F /	73 Yrs. Months Days Hours Min.	(Month, Day, Year)	Country) ANA
95 19.	· ·	Usual Residence of Decedent		,—		· ·
rylan		10a. State 10b. County	10c. Cit	y, Town or Location		10d. Inside City Limits
the Marylar 28s-f ehow	ct S	MD Harton	rd	Street		1 ☐ Yes 2 No
ith th	를	10e. Street and Number	1.1 01	10f. Zip Code	10g. Citizen of Wha	it Country?
6 after death with the Maryla or tierns 23s or 28s-1 sho	Funeral Director	2216 DECK H	fill Ra.	21/54.	001	Anna tadian
ter dea	une	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 Yes 210 No	.S. 13. Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.) 14. Hace - Black, 1	American Indian, White, etc.
36 rs aft I', or	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	1 ☐ Yes 2 € No Specify:	Specify:	white.
21215-0036 d within 72 hours after death with the Maryland giene.	ed	15. Decedent's Ed	ducation	16a. Decedent's Usual Occupation	16b. Kind of Busin	ess/Industry
21215-0 4 within 72 hopiene.	plet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	king	
~ · O n 5 + *	Completed	ank.	College (1 401 07)	homemaker	(a) hor	RO.
O D By	Be	17. Father's Name (First, Middle, Last,)	18. Mother's Nam	ne (First, Middle, Maiden Sumame)	
		HARRY De	enk.	15al	oel. Morrisse	2 y .
2 sh and and is m		19a. Informant's Na e/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ru	ral Route Number, City or Town, Sta	tel, Zip Code)
and and maz7		Sharon Gara	S-7	Place of Disposition (Name of	Date 20c. Location - Cit	21154.
More Pages 1	5	20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	semetery, crematory or other place)	Date 20c. Location - Cit	y or rown, State
		*4 Donation 5 □ Other (Specif		rdens of taith. 14-5	5-04. no aa	1-e, m+>
H3/ Baltimo	Suce	21. Signature of Funeral Service Lices	1 1 +7	22. Name and Address of Facility	EWPORT Ne, FOI	CESTIFICE,
		232 Part 1 Enter the disease or com	plications that caused the deat	EVANS FUNERAL CHAI	PGL-BELAIR, M	D 21234.
		shock, or heart failure List only		h. Do not enter the mode of dying, such as cardiac	The state of the s	Interval Between Onset and Death
Physici /Medi		Immediate Cause (Final disease or condition resulting in death)		c obstructive Pu	Imanary Wisease	20 years
	_		Due to (or as a conseq	TENSION		20 y ears
200	e le	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	10.010/0		Loyeurs
> P	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
#3/4 60, be executed	Exa	resulting in death) Last	Due to (or as a conseq	uence of):		
17 P 2 %	cal	(d			
Box 6870 Beath certificate to attending physic	Med	IF FEMALE.				
SOX Ith cen	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		23d. Date o	f delivery Day Year
O. B	by Physician/Med	in the past 12 months? 1 □ Yes 2 ☑ No	4□Pregnant at time of d 9□Unknown	eath 5 🗆 Other (specify)		Day Tour
P.O. that the ded by the	Phy	9 Unknown	pontributing to death but not reco	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribu	to to the cause of death?
ds,		Part II. Other significant conditions (contributing to death but not res	uning in the underlying cause given in Faith.		Probably 4 Unknown
Cord	Completed					
	n jdu				24a. Was an autopsy prio dea	e autopsy findings available r to completion of cause of th?
Rec Beaw						Yes 2□ No
Re la rie has	S					
	Be	25. Was case referred to medical examiner?	Hospital:	Othors	th (Check only one)	
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		For State Registrar	State of	Maryland /		artment tificate			and M		giene Reg. No. Z	004	10	39
Physic		1. Decedent's Name (First, Middle, Last) 2. Date of Month							2. Date of De Month	Day Year				
/Medi Examii	-36	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital					4b. City, Town, or Location of Death Baltimore				4c. County of Death			
Funeral Director		216-12-2110	5. Sex 7. 1 M M 2 □ F	Age (In yrs. last 88	birthday) Yrs.	If Under 1 Months [Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da July 2	th 4, 1915	9. Birthp Cour Mar	place (State o. htry) yland	r Foreign
Maryland a-f show	ctor	75.									10d. Inside Cil 1∭Yes			
with the	Director	10e. Street and Number 4669 Falls Road				10f. Zip C	ode 212	09			10g. Citizen o	of What Cour SA	ntry?	
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, tre Medical Exactline from the filed at	by Funerai	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes Give			. Was Decedent of Hispanic Origin? (Spe If Yas, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 No Specify:			Rican, etc.) Black, V					
Sermit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiener and mortant: if item 27 is marked other than "natural, or may injury or other traumatic event, I'm Medical Examples.	Completed	15. Decedent: (Specify only highest Elementary/Secondary (0-12) 10	Education	(Give life. I	dent's Usual Occupation kind of work done during most of working DO NOT use retired) nachinest				ing	16b. Kind of Business/Industry un			unk	
should be filed and Mental Hygic marked other umatic event, in	To Be Co	17. Father's Name (First, Middle, Last) Harry Worsham 19a. Informant's Name/Relationship (Type, Print) 19b. Mai					1	8. Mother's Name (First, Middle, Maiden Sumame) Catherine Betz d Number or Rural Route Number, City or Town, State, Zip Code)						
Pages 1 and 2 should nent of Health and Mer int: If Item 27 is marke iry or other traumatic		Susan T. Priest/ 20a. Method of Disposition 1 □ Burial 2 □ Cremation	friend Greenoval from St	4250 Falls Road Baltim				Ltimo		10 1				
permit. Pages Department of Important: If I any injury or once.		4 ☑ Donation 5 ☐ Other (Sp. 21. Sign ture of Funeral Service L. Romand S.	//	rector	St Ba	Name and Ar	Address	of Facility	oard	655 W.	Balti:	nore S	treet	
certificate be executed ding physician and Example and Example as the burial-transit	Ilcal Examiner	23a. Palt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									ween Death			
death certific e attending p id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)					у				23d. Date of delivery Month Day Year		
law requires that the de as been signed by the a 2 should be detached I	þ	Part II. Other significant condition	ts contributing to death but not resulting in the underlying cause given in Part I.						10	3e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Horiknow			inknown	
The ate ha	e Completed									24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No			tvallable tuse of	
ng Phy Iter this neral d	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig:	28a. Date of (Month,	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?					rsing Ho	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification;	3 Suicide 6 Could no determine	ned 286. Place o	Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
he Hospi in 24 hou he Funer pletely fill	edical													
To t with To t	×	1 / / / /		mana MD 547123							29d. Date signed (Month, Dey, Year) MARCIT 25, 2004			
		30. Name and address of person v 31. Date filed (Month, Day, Year) APR 0 6 200	no completed cause	of death (Item 23	la) (Type,	Print) NON/ BA	ME	76	101	SE, M	201E	- ur 215	VIV-7	xh
St Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 6 200	32. Rec	gistrar's Signature	for	parks	1							

			ા	ate of Maryland	•	nent of F cate of I			giene Reg. No?	1. 1	0005		
			. Decedent's Name (First, Middle, Last)		2. Date of Dea	ath	3.	Time of Death					
	Physicia		HERMAN YOUNG					Month Day Year MARCH 29, 2004 12:55p					
	/Medica Examine		a Facility Name (If not institution, give street	and number)		4	4b. City, Town, or Lo			Death	12,75		
			MARINER NURSING CEN	TER			CATONSVIL			CIMORE			
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	Mor	Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h v, Year)	Birthplace Country)	(State or Foreign		
	Director		246-12-6228 Jayal Residence of Decedent	79	Yrs.			9-28-1			CAROLINA		
	and									10d. I	nside City Limits		
	uth with the Marylar 23a or 28a-f show ust be notified at	ō	MD. N/A	BA	ALTIMORE					1	Yes 2□No		
	28a	Director	Oe. Street and Number		10	f. Zip Code			10g. Citizen of Wha	at Country?			
)	h with		2644 MARBOURNE AVE.			2123	0		USA				
	frems 2	Funerai	1. Marital Status 12. W	as Decedent Ever in U,S	. 13. Was E		lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-					
Maryland 21215-0036	Jrs 8	2	1 Never Married 2 Married 11	med Forces? ☑ Yes 2 ☐ No Yes, Give ear or Dates:		as 21 No	Specify:	rican, etc.)	Black, White, etc. Specify: BLACK				
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade com	16a. Decedent's	Usual Occup	ation during most of working	na	16b. Kind of Busin	ness/Industr	у			
7	ithin	du		life DO NOT use retired)									
2	ygi ed			-0-	DRI	VER		/=	TRUCKIN	IG			
and	Saby C	m	7. Father's Name (First, Middle, Last)				18. Mother's Neme						
ž	should the manked umartic	္	JOHN YOUNG 19a. Informant's Name/Relationship (Type, P	rine)	105 Mailing Ada	denos (Ctrost		ARET YOU		to Tin Our	101		
Ma	d 2 si fith an 17 si si si si si si si si si si si si si	5	WILMA YOUNG-HILL (DAI				a <i>nd Number or Run</i> a RNE AVE。 E		-				
	E E E	1	Oa. Method of Disposition	20b. Pla	ce of Disposition	(Name of		Date	20c. Location - Cit				
on I	8 = 5		1 ☐Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	ai irom State	metery, crematory		1						
Baltimore,	mit. Pa bartmen cortant: rinjury	-	//	GARK H D WATHAM D	KISON FOR	KEST VI	ETERANS 4-	-2-2004	OWINGS M	IILLS,	MARYLAND		
Ä	permit. Departrimporta any inju		21. Signature of Footfal Service Licens JONATHAN D. HIBNER Nama and Address of Facility PHILLIPS FUNERAL HOME, P.A. for att 1721-27 N. MONROE SI. BALTIMORE, MARYLAND 21217										
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call	the fiver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Operations and Death									
	Physician /Medical	Onset and Dei									7 /		
di	Examiner	- 11	mmediate Cause (Final disease or condition resulting in death)	ASPI	UNT	mold	melin	onia	<u></u>		Lanys		
		6		Due to (on)	as a consequence	of):					2		
	uted ansit		b	Due to los	Revenue					i .	2909		
Ć,	tificata be executed g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Ceuse (Disease or injury Due to (or as a consequence of): All was sullivitive disease.									12/11		
68760,	ysicia	- B	nat initiated events	Due to (or a	as a consequence	cot):	in av.	seme		(090		
_	tifical ig phy as th		esulting in death) Last	200 10 (0) 0		· · · · ·							
Вох	death cer e attandin ed for use		d							1			
<u>.</u>	daat daat ed fo	SICIS	art II. Other eignificent conditions contribut	ng to death but not result	ing in the underly	ing cause give	en in Part I.	23b. Did to	bacco use contri	bute to the	cause of death?		
P.O.	v requires that the death certifications signed by the attanding should be datached for use as	Physician/M						1 🗆 Y	es 2 No 3	☐ Probably	4 □ Unknown		
Records,	The law requires the state has been signed, page 2 should be d	D D						24a. Was a	en autopsv 2	4b. Were a	utopsy findings		
00	v requ	ere						perfor		availabl comple	e prior to ion of cause		
Be	The law ata has b paga 2 s	Ē						4=4	2/	of death			
Vital	ificate or, pe		5. Was case referred to medical				26. Place of Death	(Charle anh. as	22 5 QAO	1 🗆 105	2 □ No		
	Physician: this certific ral director,	Ď	examiner? 1 Yes 2 No Hospita	ll: 1 ☐ Inpatient 2 ☐ El	R/Outpatient 3	DOA Othe			ence 6 □Other (Specify)			
o	arthis eral	2	7. Man of Death 28		8b. Time of	28c. Injun Work			ow injury occurred	Ореспу			
<u>0</u>	Attending or death. ector: After by the fune	atio	Natural 5 Pending Accident investigation	(MOHIII, Day Year)	Injury M		Yes 2□No	2 □ No					
Division	tal or Attending P rs after death. el Director: After t led in by the funera		3 Suicide 6 Could not be determined 286	Place of Injury - At hom building, etc. (Specify)	e, farm, street, fa	ctory, office	2	8f. Location (Si City or Town	treet and Number o	r Rural Rou	te Number,		
Ö	e Dir	e l		January, etc. (opeany)									
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificata has completely filled in by the funeral director, paga 2:	edical	29a. Certifier (Check only one) 1 Certifying Physicien 2 Medical Examiner: 0	To the best of my knowled the basis of examination	edge, deeth occui n end/or investiga	rred et the timation, in my op	ne, date end place, e pinion, death occurre	nd due to the c d at the time, d	ause(s) and manne ate and place, and	er as stated. due to the	cause(s)		
	ithin ithin ithe on the one of the one on the one of the one on the one		9b. Signature and title of certifier	nd manner stated.		29c. License	number	2	9d. Date signed (M	fonth. Dav.	Year)		
					1	A .	1	of	3/2	a /n	A		
	AL	-	0. Name and address of person who complet	ad cause of death (form of	3eV(Type Print)	12	19/6		10	1/0	100		
	1.	1	Marcolino D.	A 16 11 Den 2	(Type, Print)	5/6	N. Po	lline	PS P	on /h	212.28		
	State		1. Date filed (Month, Day, Year)	22. Registrar's Signatur		m. Kal					4000		
	Registrar		MOD A 6 2884	- AND COM	2 July	mas 415					1		

DHMH 16 Rev 6/95

ORIGINAL

			1 - For State Registrar			Departmer Certificat	t of Heal	th and Mer	ntal Hygiei	•	10396	
			Decedent's Name (First, Min	iddle, Last)		- Cortinoat	0 01 000		Date of Death	10. C O O "P	3. Time of Death	
	Physici		Theresa	Zammataro					Month,	Day Year 5 2004	1:00A M	
	/Medic Examir		4a. Facility Name (If not institu		r)	4b City	Town, or Local	tion of Death		4c. County of Death		
1	Examir	ier				10.0%						
	Funeral		1 West Conway 5. Social Security Number		. 100 .ge (In yrs. last b	irthday) If Under	Balti rıYear liGü	nder 24 Hrs. 8.	Date of Birth	N/A 9. Birth	place (State or Foreign	
	Funeral Director		054-09-4259	1 ☐ M 25 🛣 F	85	Yrs. Months	Days Ho	urs Min.	(Month, Day, Yea	1919 N/2	place (State or Foreign ntry)	
			Usual Residence of Decedent						dreif 45	1717, 14/2	.1	
	ylan how		10a. State 10b. Cou	nty	10c. City, Tov	n or Location					10d. Inside City Limits	
	a-fe	Director	MD N	/A	Ва	ltimore					1 X Yes 2 No	
	is within 72 hours after death with the Maryland piene. iten. It a Macilcal Examinat must be notified at	lre	10e. Street and Number			10f. Zip	Code		10g.	Citizen of What Cou	ntry?	
] E	1 West Conway	St. Apt. 11	.06		212	.01		USA		
	ems ems	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. Was Dece	dent of Hispani	ic Origin? (Specify exican, Puerto Ric	Yes or No-	14. Race - Ameri Black, White,		
9	or It	F	1 Never Married 2 N	No	1 ☐ Yes		ecify:	,	Specify:	010.		
8	nours ural',	d by	3 S Widowed 4 □ Divord		:					Specify.	White	
7	nat	Completed	15. Deced (Specify only hig	dent's Education ghest grade completed)	168	 Decedent's Usu (Give kind of wo 	al Occupation ork done during	most of working	16b.	. Kind of Business/Ir	dustry	
12	within lene. than	mp	Elementary/Secondary (0-12	2) College (1-4or	5+)							
22			12 17. Father's Name (First, Midd	tle (ast)		Homemal		Mother's Name (Fi	irat Middla Main	Own Hor	ne	
ano	d tal	Be						·		en sumame,		
Maryland 21215-0036	~ 0 ~ ~	10	Settimeio Rosa 19a. Informant's Name/Relatio		10	h Mailine Address		ulia Fig		y or Town, State, Zij	Code	
Z Z	2 d d a										Code)	
	s 1 and if Health Item 27 other tr	-	Virginia Pask	off/Daughter		129 W . Let of Disposition (Na)		Baltimo	re, MD 2	Location - City or To	own State	
ية	it of it of it of or o		1 ☐ Burial 2 🗖 Crematic	on 3 Removal from State	e cemete	ery, crematory or c	ther place)		200.	Location - City of Th	JWII, State	
Ħ		l s	`4 □Donation '5 □ Other		Balto	-Wash Cre				urel, MD		
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Servi	1 H Q	1	Sterlin 736 Edi	ng Asht nondson	on Schwa Ave. B	b Funera altimore	al Home, l e, MD 2122	Inc. 28	
			23a. Part1. Enter the disease spock, or heart ailure. L	, or complications that cause list only one cause on each	ed the death. Do	not enter the mod	le of dying, such	h as cardiac or re	spiratory arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition F and Mus Com a									
	/Medical Examiner		resulting in death)	Due to (ona	s a consequence						years	
			Sequentially list conditions.									
	₽ #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury	Due to (or a	s a consequence	of):						
	ecuter nd trans	am	C. Cause (Disease or injury that initiated events C. Cesulting in death) Last Due to (or as a consequence of):									
760,	te be executed ysician and e burial-transit											
376		Ical		d								
89	death certifica e attending ph d for use as th	Physiclan/Med	IF FEMALE:									
Вох	ith ce itend		23b. Was decedent pregnant in the past 13 morths? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy						li li	23d. Date of delive		
	0 0		1 ☐ Yes 2 ☐ No	4☐ Pregnant a 9☐ Unknown	at time of death	5 Other (sp	ecify)			Month	Day Year	
P.O.	that the ded by the detached	Phy	9 Unknown		Long Bida by							
	signed be de	by	Part II. Other significant cond	art I.	23e. Did tobacco use contribute to the cause of de							
orc	w requir been si should	Completed	Abdomenal aortic anevrysm						1 VYes 2 No 3 F		robably 4 Unknown	
Vital Records,	S C4		Abdome	nal dort	1 car	revrys	m		24a. Was an autopsy	prior to co	psy findings available mpletion of cause of	
<u> </u>		5				1			performed? 1 ☐ Yes 2 ☐	death?		
ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to med examiner?				1117-7-1111	Place of Death (Cl	heck only one)			
	S S	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat	ient 2 ER/O	utpatient 3 DC	Other: 4	Nursing Home	5 Residence	6 ☐ Other (Specify	y)	
n n	ng P	ü	27. Manner of Death 1 ☑Natural 5 ☐ Pen	28a. Date of Inj	ury 28b. ay Year)	Time of 2 Injury	8c. Injury at Work?	28d.	Describe how in	jury occurred		
Division of	Attending r death. sctor: After by the funer	atle	2 Accident investigation M 1 Yes 2 No									
Ĕ	r Att ter de irect	Certification:		ald not be ermined 28e. Place of Ir building, e	njury - At home, fa etc. (Specify)	arm, street, factory	eet, factory, office 28f. Locating City of Cit			tion (Street and Number or Rural Route Number, or Town, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		/									
	Hosp 4 hou Fune Bity fill	ca	(Check only 2 Medic	fying Physician: To the best cal Examiner: On the basis	of examination ar	e, death occurred nd/or investigation	at the time, date, in my opinion.	te and place, and death occurred a	due to the causer	(s) and manner as st	ated.	
	the hin 2 the l	Medical	onej	and manner s	tated.							
	To Too		29b. Signature and title of cert		1	290	License numb		29d. D	ate signed (Month,	Day, Year)	
7	0,		Jun	allong 1	W		1146	,389	A	PVI15	2004	
	1		30. Name and address of pers				D . A . C	`	145 5	V		
			J. WILL HOM	4, MD 3	•	Paul,	roalt	i move	MID ,5	-1505		
487	∜ Sta Registr		31. Date filed (Month, Day, Ye		rar's Signature		Al red					
	negisti	वा	APR OF	ZUU4 Deker	10	apor	in					

			1- For State of Maryland Registrar	/ Department of Health and Certificate of Death	Mental Hygiene Reg. No. 20	04 10397
	Physici	an	1. Decedent's Name (First, Middle, Last)	mas Zuk Jr.		3. Time of Death
	/Medic	cal	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Oeal	th 4c. County of I	7.00
	Examir Funeral Director	ier	Franklin Square Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last 212-46-2166 152 M 2 F 55	Bosedale	8. Date of Birth 9.	
	land bw		Usual Residence of Oecedent 10a. State 10b. County 10c. City, 1	Town or Location		10d. Inside City Limits
	Ba-f sh	ctor	MD Baltimore	Middle River		1 ☐ Yes XIXNo
	3e or 2	Dire	10e. Street and Number 520 Holly Hunt Road	10f. Zip Code 21220	10g. Citizen of Wha	t Country?
980	d within 72 hours after death with the Maryland jene. r than "natural", or Itema 23e or 28e-f show the Macical Examinationalize natified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1☆Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1★ Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ★ No Specify:	Specify Yes or Noto Rican, etc.) 14. Race - Black, V Specify W	American Indian, White, etc. hite
21215-0036	id within 72 ho giene. er then "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) Mechanic	16b. Kind of Busin	ess/Industry
Maryland	2 should be filed v and Mental Hygie is marked other t reumatic event, III	To Be (John Thomas Zuk Sr.		me (First, Middle, Maiden Surname) oline Leader	
	2 = 2 T		19a. Informant's Name/Relationship (Type, Print) John Zuk 111 /son	195. Mailing Address (Street and Number or Ri 1971 Snuder Ave.		
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 inty or other tree		cem	e of Disposition (Name of netery, crematory or other place) viewCrematory 4/	Date 20c. Location - City 5/04 Baltimo:	
Balti	permit. Pages Department of h Important: If ite any injury or of once.		21. Signature of Funeral Service Licensee		onnellyFuneralH e. Baltimore MD	
*	Physician /Medical Examiner	Examiner	23a. Pant 1. Enter the disease, or complications that caused the deeth. shock, or heart failure. List only one sause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1 Cancer metastatic	•	Approximate Interval Between Onset and Oeath Comments
P.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Due to (or as a consequent of d.	y aath 3⊟Ectopic pregnancy	23d. Date of Month	delivery Day Year
	quires that in signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting the Preumonia	ng in the underlying cause given in Part I.	23e. Did tobacco use contribut	e to the cause of death? Probably 4 Unknown
Vital Records,		Completed	Of Manager desired to a second		autopsy prior performed? death	e autopsy findings available to completion of cause of n? res 2 \(\text{No} \)
\ <u>\text{\tin}\text{\ti}\\\ \text{\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\texi}\text{\ti}\}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\ti}\}\tittt{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\text{\text{\texi}\titt{\text{\texi}}\\ \titt}\tittt{\text{\texi}\tittt{\text{\texi}\tittt{\ti}\text{\t</u>	Physician: 1 this certifical ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER.	Othor	ath <i>(Check only one)</i> Home 5 ☐ Residence 6 ☐ Other <i>(S</i>	
ion of	ding I. After fune	-		Bb. Time of lnjury at Work? M 1 Yes 2 No	28d. Oescribe how injury occurred	яр <i>өспу)</i>
Division	tal or Attendi s after death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Street and Number of City or Town, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funerel Dire completely filled in b	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	idge, death occurred at the time, date and place a and/or investigation, in my opinion, death occu	, and due to the cause(s) and manner irred at the time, date and place, and o	r as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and tiple of certifier	29c. License number	29d. Date signed (M	* '
•	19		30. Name and address of person who completed cause of death (Item 23	D37612	April 2.	2004
	10		M. A labrash, MP 1601	S. Tollgate Rd	BERAIR MD	21015
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	b South		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dey 2004 **Physician** 1205 AM Kennard Joseph Bostic /Medical 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner BURNIE JAME ARENDE NORTH ARUNDEL GLEN HOSPITAL If Under 1 Year | If Under 24 Hrs. | Hours | Min. 8. Date of Birth (Month, Dey, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Funeral Deys 1**√** M 2□ F Months Director 219-34-3054 07/16/1936 Maryland Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Marylend nent of Heelth end Mentel Hygiene. Int: If item 27 is marked other than "natural", or frams 23e or 28e-f ahow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flams 23a or 28a-f ahow traumetic avant, the Medical Examinat must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Maryland Queen Anne's Sudlersville 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 107 Miller Street 21668 USA 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 School Bus Contractor Transportation 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Stephen Enoch Bostic Lula V. Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mary J. Bostic/Wife 107 Miller St., PO Box 212, Sudlersville, MD 21668 ortant: If item 27 injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Depertment c Important: If i any injury or Sudlersville Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3/7/2004 Sudlersville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Fellows, Helfenbein & Newnam Funeral Home, P.A. Part Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiretory arrest,

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Approximatel Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical FOIERMONIA **Examiner** Due to (or es a consequence of): Physician/Medical Examiner STACE CENAL or Attanding Physician: The lew requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, ROSTATE Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 ☐ Yes 2 ☑ No 1 Yas 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1□ Yes 2☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To within 24 hours efter deeth. To the Funeral Diractor: After this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner steted. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20(1) 1345149 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) flew Burnie MD 21061 DAY ABAHO 301 Jospital Drive 31. Dete filed (Month, Day, Year) Strer's Signeture State MAR 0 8 2004 Registrar

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryla	and / Dep	artme		and N	lental Hyg	iene og. No. (2004	10399
	Physic /Medi Examir	cal	Ella Sinclair 4a. Facility Name (If not institution, give s 108 Belvedere	treet and number)			y, Town, or Locatio	on of Death	Month March	Day 6	2004 unty of Death	3. Time of Death 1:10 a. M
	Funeral Director		Social Security Number 6. Sex		rs. last birthday, Yrs.			der 24 Hrs. S Min.	8. Date of Birth (Month, Day, NOV • 6		orchest 9. Birthp Coun Mar	lace (State or Foreign cyland
0	death with the Maryland ims 23a or 28a-f show ims 15a notified at	ector	10a. State 10b. County MD Dorches 10e. Street and Number		City, Town or L		Cambr	idge				0d. Inside City Limits 1° Yes 2 □ No
2	ath with	Funeral Director	108 Belvedere Ave	e.		101. 2	ip Code 2161	13	1		of What Coun	try?
	be filed within 72 hours after death with the Marylan table Hygione. d other than "natural; or Items 23a or 28a-1 show event, The Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	İ	Was Dec il Yes, sp 1 Yes	edent of Hispanic (ecify Cuban, Mexic 2 No Specia		ecify Yes or No- Rican, etc.)		Race - Americ Black, White, on Black, White, on the second with the second win	
-5121	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	e kind of w DO NOT	ual Occupation rork done during m use retired) Ve secret		ing		of Business/Inc	
	Men Men arke	To Be Co	17. Father's Name (First, Middle, Last) Robert James S:				18. Moi	ther's Name	(First, Middle, M Hughes	Maiden Sur	name)	
	nd 2 sh sith and 27 is m r treum		19a. Informant's Name/Relationship (Type Richard L. Brown	husband			ss (Street and Nurr edere Ave				wn, State, Zip 21613	Code)
Baltimore,	S - = 0		20a. Method of Disposition 1 Suburial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	o. Place of Dispo cemetery, crea	matory or	ame of other place)	1	0/04		on - City or To	
Baiti	permit. Pege Department o Important: If any injury or once.		21. Signatur of Funeral Service License		2;	2. Name	and Address of Fac Locust St	cility Th	nomas Fur	neral	ock, MI Home F 21613	
	Physician /Medical Examiner	er	23a. Part Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	ations that caused the de cause on each line. Due to (or as a cons	equence ol):		ode ol dying, such a		and the same of th			Approximate Interval Between Onset and Death
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ñ j	at the death certificate by the attending physiached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 W No 9 Unknown	ic. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	⊒Ectopic □ Other (s	pregnancy			23d.	Date of deliver Month	y Day Year
rds, P	w requires that the been signed by the should be detache	by	Part II. Other significant conditions conf	ributing to death but not r	esulting in the u	nderlying	cause given in Par	rt I.		acco use c	/	a cause of death?
Hec	the law ate has b page 2 st	Completed							24a. Was an autopsy perform	ed2/	b. Were autop prior to com death? 1 \(\text{Yes} \) 2	sy findings available pletion of cause of
or vital	rnysician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \)	ospital: 1 Inpatient 2	 ☐ ER/Outpatier	nt 3 🗆 D	0.11		re 5 XResider		Other (Specify)	
ס ויס	ath. ath. rr: After the		27. Manner of Death 1 12 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f M	28c. Injury at Work? 1 ☐ Yes 2	2	28d. Describe how			
DIVISION	To the trospies or Attending Priys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	cify)				28f. Location (Stre City or Town,	State)		
	ie nosp 124 hou ie Funei letely fil	ledicai	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Exemin	cian: To the best of my ker: On the basis of exami and manner stated.	nowledge, death nation and/or in	h occurred vestigatio	d at the time, date a n, in my opinion, de	and place, a eath occurre	and due to the car ad at the time, da	use(s) and te and plac	manner as sta e, and due to t	ted. the cause(s)
,	withir To th	W	29b. Signature and title of certifier			29	c. License number	1 500 -	29	d. Date sig	ned (Month, D	ay, Year)
		ğ	30. Name and address of p-rson who com	_	em 23a) (Type,	Print)	D 36	12		134	08	- 634- 21613-
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 20	32. Rysistrar's Sig	nature	re Par	ED 57	Con.	KIBRI	N.E.	KU) Z	1613

DONOTHY Jackson Blades Compared to the County of Daniel County of Dani				For State Registrar	State of Ma	aryland / De		Health and M	ental Hyg	_	
DOTOCHY Jackson Blades Families Families Dotochy Jackson Blades Cambridge				1. Decedent's Name (First, Middle, L	ast)						3. Time of Death
## Contract of Death Tono—B High St. 100.B High St. 1				Dorothy	Jackson	Bla	des			12 2004	6:35 a ^M
The control purpose of the control purpose of				4a. Fecility Name (If not institution, g	ive street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	alh
25.12.6.641 27.12.6.641 28.11 28.12.6.641 28.12.6.641 28.13.6.6.6.6.6.6.6.6.6.6.6.6.6.6.6.6.6.6.				100-B High St.			Cambr	idge		Dorches	ster
The property of the property o				215-12-6441			Months Days	Hours Min.	8. Dete of Birth (Month, Day, Feb. 16	, 1923 N	nthplace (State or Foreign ountry) Maryland
Security Security	1	pug *	}			10c City Town or	Location				10d Inside City Limits
Security Security	3	Sa-f sho	ctor	MD Dorch	ester		Cam	bridge			1 X Yes 2 □ No
Security Security	Se	th with the 23s or 2 ust be n	al Dire				10f. Zip Code	21613	1	-	ountry?
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Physician (Medical Examiner) Physic	2	and ealth m 27			daughter	46. 10			-		
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Physician (Modele) Sample of the part of	Ball	Depar Impor eny in		I fin Glore	/		700 Locus	t St., Cam	bridge,	MD 21613	
Due to (or as a consequence of): Comparison of the comparison o		/Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as	a consequence of):					Interval Between Onset and Death 3 month
The state of the s	,0928	sicie /sicie e bur	cai	that initiated events	cDue to (or as	a consequence of):					
25. Was case referred to medical examiner? 1 Yes 32 No	Вох	t the death certiff by the attending ached for use as	hysician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetel death		y			-
25. Was case referred to medical examiner? 1 Yes 3 No	rds, F	quires tha	ed by P	Pan II. Other significant conditions	contributing to death b	ut not resulting in the	e underlying cause giv	ven in Part I.		L-	
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and didess of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filled (Month, Day, Year) 32. Registrar's Signature	II Reco		Complet						autops: perforn	y prior to death?	completion of cause of
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29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and diress of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filled (Month) Day, Year) 32. Registrar's Signature	sion	ending I eath. or: After the funer	ation	Datural 5 Pending investigate	(Month, Da)	y Year) 280. Time y Year) Injur	y M 1	y at rk? Yes 2 □ No	sa. Describe no	w injury occurred	
30. Name and aldress of person who completed cause of death (Item 23a) (Type, Print) Eugene Newmer 20 503 Byrn St Cambridge MO 216) State 31. Date filed (Month Day, Year) 6 200 32. Registrar's Signature	Divis	tel or Att rs after d el Direct ed in by	Certifi	determine	286. Place of inju	ury - Al home, farm, c. (Specify)	street, factory, office	2	8f. Location (Sti City or Town	reet and Number or R , State)	ural Route Number,
30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Eugene Newmer 20 503 Byrn St Cambridge MO 216) State 31. Date filed (Month Day, Year) 6 200 32. Registrar's Signature		he Hospi in 24 hou he Funer pletely fill		(Check only 2 Medical Ex	aminer: On the basis of	examination and/or	eath occurred at the tir investigation, in my o	me, date and place, a pinion, death occurre	nd due to the ca d at the time, da	tuse(s) and manner at the and place, and due	s stated. e to the cause(s)
30. Name and aldress of person who completed cause of death (Item 23a) (Type, Print) Eugene Newmer 20 503 Byrn St Cambridge MO 216) State 31. Date filed (Month Day, Year) 6 200 32. Registrar's Signature		To t To tl	Σ	29b. Signature and title of certifier	41 -		29c. Licens	e number	29	d. Date signed (Mont	h. Day, Year)
State 31. Date filed (Month Day, Year) 6 200 32. Registrar's Signature				Muyeno /	Veno:	>2/	175	1793		3/12/0	24
State 31. Date filed (Month Day, Year) 6 200 32. Resistrar's Signature				30. Name and a dress of person wh	11	eath (Item 23a) (Typ	503 1	Byrn S	+ Ca	mbridge	140 21613
		Stat Registra	-	31. Date filed (Month Day, Year)	32. Registra	ar's Signature	A.v.			10	

		For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of <i>rtificate o</i>		Mental Hy		004 1040
Physicia	_	1. Decedent's Name (First, Middle, Las	•	-		·· <u>·· ·</u>	2. Date of De		3. Time of Death
Physicia: /Medica	al .	Cecilia Koski Bl					March	8, 2004	12:45 A M
Examine	er	4a. Fecility Name (If not institution, give				n, or Location of De	ath	4c. County	of Death
		Mallard Bay Care			Cambri			Dorc	hester
Funeral Director		210-20-3307	ex 7. Ag	e (In yrs. last birthday) 79 Yrs.	Months Day			9,1924	9. Birthplace (State or Foreig Country) Maryland
land	+	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
Maryland -f show	ō	Maryland Dorchest	ar	Secret	0.237				1 XYes 2 No
with the a or 28a	Funeral Director	10e. Street and Number		Secret	10f. Zip Code	9		10g. Citizen of W	hat Country?
38.0	<u> </u>	117 Poplar Street			2	1664		USA	,
ms 234	Jera	11. Marital Status	12. Was Decedent	Ever in U.S. 13.		of Hispanic Origin? (uban, Mexican, Pue	Specify Yes or No		- American Indian,
le di	ρ Δ	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:	No	if Yes, specify Ci 1 □ Yes 21ሺ N		irto Rican, etc.)	Specify:	white, etc. White
"natural",	Completed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occ	cupation		16b. Kind of Bus	
it of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, Ins Medical	e d	(Specify only highest gra	de completed) College (1-4or 5	(Give	kind of work dor DO NOT use reti	ne during most of wired)	orking		,
er th	0	8			maker			0wn	Home
al Hy	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	, Maiden Sumame)
h and Mental Hygiene. 7 is marked other than " traumatic event, the Max	0	Joseph C. Koski				Helen	May Will	oughby	
and is mu		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailii	ng Address (Stre	et and Number or F	Rural Route Number	er, City or Town, S	State, Zip Code)
n 27 er tr		Kay B. Townsend/D	aughter	5407	Chateau	Road, Ea	st New M	arket, M	D 21631
it it		20a. Method of Disposition	S	20b. Place of Dispo cemetery, crer	sition (Name of	lace)	Date	20c. Location - C	City or Town, State
artment ortant: h injury o e.	4	1 X Buriał 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	East New		l l	1/2004	East New	Market, MD
Department of Health Important: If item 27 any injury or other tr once.	1	21. Signature peral Service Licen	See (\	1 1 22	2. Name and Add	fress of Facility	2000 - 124 F-2-01		
Departr Imports any inju	1	x cenury		aller	eller Fi O6 Main	uneral Ho Street,	me, P. O East New	Box 20	7 MD 21631
hysician Amending physician and previous as the purial-transit and the same as the purial-transit and the same and the sam	ers.	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Metas Due to (or as c.	tive Heart a consequence of): tatic Colo a consequence of): a consequence of):					
ed by the attending phy detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetel death 3 ☐	Ectopic pregnan		- Tu	23d. Date Mont	,
	y Pr	Part II. Other significant conditions co	intributing to death bu	it not resulting in the ur	nderlying cause g	given in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
uld be	Da						1 🗆 Y	′es 2 □ No 3	M Probably 4 □Unknown
s been si should	сощыете						24a. Was	an 24h W	are autoney findinge available
page 2	E .	· · · · · · · · · · · · · · · · · · ·					autop perfor	sy pri rmęd? de	ere autopsy findings available or to completion of cause of ath?
certificate		25. Was case referred to medical					1 Yes	21XNo 1	Yes 2□No
is certific director.	ă	examiner?	Hospital:	• • 		at .	ath (Check only or		
5 7 7	- 1	27. Manner of Death		nt 2 ER/Outpatien y 28b. Time of	3 DOA	4 Mursing I		ence 6 Other	
leath. tor: After th the funeral		1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) Injury	28c. Inju Wi M 1 [ork? □Yes 2 □No	zod. Describe (1	low injury occurred	•
rec rec lby	a compa	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At home, farm, stre (Specify)			28f. Location (S City or Tow	Street and Number n, State)	or Rural Route Number,
led C		200 000000 1000000000000000000000000000							
Virgin 24 nours and To the Funeral Discompletely filled in Madical Cor.	200	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exemi	iner: On the basis of and manner star	f my knowledge, death examination and/or inv	occurred at the testigation, in my	time, date and place opinion, death occi	e, and due to the curred at the time, d	ause(s) and manr date and place, an	ner as stated. d due to the cause(s)
mple M		29b. Signature and title of certifier	210 11211101 3(2)	in c	29c Licen	nse number	2	29d. Date signed (Month Day Voorl
₽ 8		Da L	1.	W	H0059				
	-	Office of				7/3		March 11	, 2004
	1	30. Name and add/ess of person who c Patricia Johnson				Combant 1-	M 1	-1 01610	
				Bramble S			, Maryla	nd 21613	
State Registrar		MAR 1	2 2004	's Signature	Acres 1	•			

			1 - For State Registrar	State of M	laryland / Depa	artment of He	ealth and Me	ental Hygier	ne 2004	10402
ı	Dhunini		1. Decedent's Name (First, Middle	, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Anna	В.	Ballanti	ne		March 14		1:15 AM M
	Examin	er	4a. Facility Name (If not institution	, give street and number)	4b. City, Town, or Lo	ocation of Death		4c. County of Death	
			31699 Dublin R		and the same to be bright to 1	Princess		D. A / D	Somerset	
н	Funeral Director		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday) Yrs.		Hours Min.	B. Date of Birth (Month, Day, Yea		nplace (State or Foreign untry)
			219-03-5900 Usual Residence of Decedent		84			03/04/192	20 Mar	yland
	72 hours after death with the Maryland rieturel, or tems 23e or 28e-f show dical Example or 18e-f show		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e-fs	Director	MD Somer	set	Princess	Anne				1 ☐ Yes 2XNo
	ith the	Oire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	intry?
	236 unit	rai	31699 Dublin Ro	ad		218	353		USA	
	tems ver	Funerai	11. Marital Status	12. Was Deceden Armed Forces	Ever in U.S. 13.	Was Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Spec Mexican, Puerto Ri	ify Yes or No- can, etc.)	14. Race - Amer Black, White	
36	s afte , or it	γFι	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced	If Yes, Give	No		Specify:		Specify:	, 5.0.
Ş	hour turel	Completed by	15. Decedent	Year or Dates:		tanta Harri Orania		1 40	W	hite
,	in 72	olet	(Specify only highes	t grade completed)	(Give	dent's Usual Occupation kind of work done dure DO NOT use retired)		160.	Kind of Business/li	ndustry
77	with jene.	шo	Elementary/Secondary (0-12)	College (1-4or		ewife)wn Home	
Maryland 21215-0036	e filec I Hyg othe ent,	Be C	17. Father's Name (First, Middle, I		11045		8. Mother's Name (
<u>a</u>	uld be Aenta rked tic ev	To B	William Henry B	edsworth		I	Lena Bloo	dsworth		
ary	sho and N s ma		19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Mailin	g Address (Street and	Number or Rural I	Route Number, City	or Town, State, Zi	p Code)
Σ.	and 2 salth n 27 i		Mary L. Bradsha	w/Daughter	26821	Robert Bu	ırns Lane	, Salisbu	ıry, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any njury or other treumatic event, It a Madical Exacticer cust be reciliated at once.		20a. Method of Disposition 1X Burial 2 □ Cremation	3 Pemoval from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)	Dat	te 20c.	Location - City or T	own, State
Ĕ	Pag ment ent:		4 □ Donation 5 □ Other (Sp			ws Episcop	oa1 03/18	/2004 Pri	ncess An	ne, MD
391	ermit. epart nport ny in	1	1. Signature of Funeral 8	censee	22	. Name and Address on nman Funer	of Facility			
_	ŭ □ ⊑ ei ol	\	ANOS OVI		100295 11	673 Somers	et Ave	Princess	Anne, M	21853
		1	23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cause only one cause of each i	d the death. Do not enti ine.	er the mode of dying, s	such as cardiac or r	espiratory arrest,		Approximate Interval Between
8	Priysician	V	Immediate Cause (Final disease or condition resulting in death)	_a. Car	aromyogi	why				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	U	1-	40		1
		.	Sequentially list conditions,	b Due to (or as	a consequence of):	wtery	msec	2.6		720N3
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	51	LV 10 lasor	hem-t	- dice	150		1427.6
	be executed sician and burial-transit	Exai	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):		00.3			- Teins
8760,	death certificate be executed e attending physician and id for use as the burial-transit	cai	,	d						J
Ó	tifical ng phy as th	ledi	2	1						
Вох	death certifica attending ph	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			23d. Date of deliv	ery
-	ed to	Physician/Med	in the past 12 months? 1 □ Yes 2 ☑ No	4□Pregnant a		Other (specify)			Month	Day Year
0	that the de led by the a detached	Phy	9 Unknown	<u> </u>						
	9 P 9	þ	Part II. Dther significant condition	ns contributing to death t	out not resulting in the un	iderlying cause given i	n Part I.		use contribute to t	
20	w requir been si should	Completed						1 ☐ Yes	2 MNo 3 Prot	bably 4 Unknown
Records,	e law has b	npie						24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
	ysicien: The is certificate hidrector, page							performed?	death? lo 1 ☐ Yes	20 No
Ĭ	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			6. Place of Death (
Division of Vital	Phys r this ral di	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpati		28c. Injury at	4 Nursing Home	5 Residence 1. Describe how inj	6 Other (Specif	y)
o	ding P th. After t	tion	1 Natural 5 Pending 2 Accident investiga		y Year) Injury	Work?	2 □ No		ary occarrod	
<u>ISI</u>	I or Attendi after death. Director: A In by the fu	ifica	3 ☐ Suicide 6 ☐ Could no	ned 286. Place of in	jury - At home, farm, stre	et, factory, office	28f	. Location (Street a	and Number or Rura	al Route Number,
á	i fie	Certification;	4 Homicide	building, e	c. (Specify)			City or Town, Sta	te)	
	ospit hour unere ty fille		29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical E	Physician: To the best	of my knowledge, death	occurred at the time,	date and place, and	due to the cause(s) and manner as s	tated.
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	ledical	one)	xaminer: On the basis of and manner st	ated.			at the time, date at	no place, and due to) the cause(s)
	To To	Σ	29b. Signature and title of pertifier	15		29c. License nu	Imber 0 1	29d. D	ate signed (Month,	Day, Year)
			7014	4		17 >	5000	0	1) 16	104
			30. Name and address of person w	no completed cause of c	eath (Item 23a) (Type, F	Print) Phi	MC C	ALTSB	ury w	1000 CW
	Sta	0	31. Date filed (Month, Day, Year)	32. Regishr	ar's Signature	1		7, 0 0	-11	
	Star Registra			9 2004		hall s				
			****	2001						

		1 - For Unpend Item Registrar 1. Decedent's Name (First, Middle			Ce	rtificate	of Health of Death		Reg.	No.200	
Physic		Derek Evan		Jr.					Month larch 20	Day 2004	3. Time of Dea
/Medi Examii		4a. Fecility Name (If not institution	n, give street and num	ber)	-		wn, or Location			4c. County of I	
Funeral		University Hos 5. Social Security Number			last birthday)	Balt:	ear If Under		ate of Birth	9.	Birthplace (State or For
Director		220-52-6413 Usuel Residence of Decedent	1 ∑ M 2□F	53	Yrs.	Months C	ays Hours	Min.	Month, Day, Ye t. 20,		Birthplace (State or For Country)
iryland ihow		10a. State 10b. County	3 1 1	10c. Cit	ty, Town or Lo						10d. Inside City Lin
the Ma 28a-1	ecto	MD Anne	e Arundel				rsville		100	02:	1 ☐ Yes 2🛣
death with the Maryland ons 23a or 28a-f show rives be neithed at	I Die	770 Stacy Oak	Way			10f. Zip Co	21108		109.	Citizen of Wha	JSA
ē # #	by Funeral Director	11. Marital Status 1 Never Married 2 Amarr 3 Widowed 4 Divorced	ied 12. Was Deced Armed Force 1 Tyes 2 If Yes, Give Year or Dat	es? E ∑ No	'	Was Decedent f Yes, specify	of Hispanic Ori Cuban, Mexicar No Specity:	igin? (Specify n, Puerto Rica	Yes or No- n, etc.)	14. Race - /	American Indian, White, etc. White
72 hou		15. Deceden (Specify only highes	t's Education		16a. Deced	ient's Usual C	ccupation lone during mos etired)	t of working	16b	. Kind of Busin	ess/Industry
rd within 72 hours all giene. er than "natural", or itte Medical Exam	Completed	Elementary/Secondary (0-12) 12	College (1-4	lor 5+)			o Owner	. or noming	Ci	rcle Ma	achine Serv
be file ntal Hy od othe avent,	Be	17. Father's Name (First, Middle,						,	st, Middle, Maid	ten Sumame)	
nd 2 should be file Ith and Mental Hy 27 is marked oth freumatic avent	2	Derek E. Brier 19a. Informant's Name/Relations			19b. Mailin	a Address (S	Per and Number	mice C		v or Town Sta	te Zin Code)
and 2 :		Helen D. Brier					Oak Way				21108
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tree		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S)		ate	Place of Dispo emetery, cren	natory or other	place)	Date Mar. 25 2004), R=	Location - City	or Town, State
permit. Departm Importa		21. Signatura of Pheral Service	Licensee	5.5	22	. Name and A	ddress of Facilit			na Parķ	Funeral Ho , MD 2114
Physician /Medical Examiner	al Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Narcota Due to (or b. Due to (or c.	as a consequence as a c	uence of):						Onset and Deat
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transt	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnar 9□ Unknow	h 2∏Fetal at at time of de n	Ideath 3 action 5 action 5	Ectopic pregn Other (specify	/)			23d. Date of Month	delivery Day Year
w requires that the bear signed by should be detact	by	Parli Other significant condition Immunosuppression D				derlying cause	given in Part I.				e to the cause of death Probably 4 []Unkn
n, ing Physician: The law requires I After this certificate has been signe funeral director. page 2 should be r	Completed								4a. Was an autopsy performed?	prior death	autopsy findings avail- to completion of cause 1? /es 2 \sum No
ysiciar s certif directo	o Be	25. Was case referred to medical examiner? 1√2 Yes 2 □ No	Hospital:	atient 2 🗆	ER/Outpatient	3[] DOA	Oth	of Death (Che	ock only one) Residence	e []Other /6	*
ding Phys n. After this funeral di	Du: T	27. Manner of Death 1 □Natural 5 □ Pending	198a Date of		28b. Time of	28c.	njury at Work?		Describe how in		респу)
I or Attendi after death. Director: A I in by the fu	Certification:	2 Accident investig 3 Suicide 6 Asould n 4 Homicide determine	- unimown	- +	ome, farm, stre	М	1 ☐ Yes 2 🔯 N	CERCI			From Ladder nwohlds Vane
To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by		29a. Certifier 1 Certifying (Check only 2XMedical 8	g Physician: To the base	Resident	dence	occurred at th	e time, date and	t place and di	nown-	(c) and manner	as stated
To the I within 2. To the I complete	Medicai	29b. Signature and title of certifier	and manner	stated.		29c. Lic	ense number		29d. C		onth, Day, Year)
										-	

Physicia /Medic Examin					Certif	ficate of	Deatl	7		Reg. No	. 20	04	1040
		1. Decedent's Name <i>(First, Middl</i> e, Last, J ohn	Franklin	Carr	011				2. Date of Do Month March	Da	y 200	ear 4	3. Time of Death
		4a. Facility Name (If not institution, give Residence: 154 B1		venue		b. City, Town, o Havr		of Death Grace	e	40	County of	Death	rd
Funeral Director		5. Social Security Number 6. Sec 214-30-2927		(In yrs. last	birthday) If	Under 1 Year Ionths Days	If Unde Hours	Min.	8. Date of Bi (Month, Di Jan 2	irth av. Year 25, 19	934	Birthpl Count Ma	ace (State or Forei ry) ryland
ra-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Har	ford	10c. City, To	wn or Locati		re de	Grac				10	ld. Inside City Limi
Baor 28 Lbeno	i Director	10e. Street and Number 154 Bloomsbury Ave	2710		,	10f. Zip Code	2107	Ω		10g. C	tizen of Wh	at Count	ry?
and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-1 show aumatic event, It's Medical Examiner must be notified at	by Funerai		12. Was Decedent Ev Armed Forces? 1 Styes 2 No If Yes, Give Year or Dates: 1		10	s Decedent of Hess, specify Cub	lispanic O an, Mexica	rigin? (Spe an, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race -	America White, e	
n "natura Medical E	Completed	15. Decedent's Edu (Specify only highest gradi Elementary/Secondary (0-12)	cation	16	a. Decedent	's Usual Occup d of work done NOT use retire	during mo	st of work	ing	C&	Gind of Busin	ness/Ind	ustry
	Be Com	Eleven Years 17. Father's Name (First, Middle, Last)	College (1-40) 3+		Vend	ding Me			e (First, Middle			1, M	aryland
d Mental narked o natic eve	٥		E. Carrol		Ob Mailine A	ddens (Ctook			Mary El				2 (1)
alth and 127 is n		19a. Informant's Name/Relationship (Ty Joyce A. Carroll	(wife)	1	_	ddress <i>(Street</i> Oomsbur				-			21078
nent of He nt: If itan iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	emoval from State	ceme	•	on (Name of ory or other place ial Gard	· .		8/04		ocation - Ci rdeen		m, State ryland
Department of Health and Mente Important: If item 27 is marked any injury or other traumatic erone.		21. Signature of Funeral Service Licens	PHENOR	u Sv.	22. Na Le c	ame and Addre e A. Pa rryvill	ss of Faci tters	ity son &	Son Fu	iner:	al Hon	ne, l	P.A.
Medical xaminer functions of prices of the p	Examiner	23a. Part1. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the cause on each line The tasta Due to (or as a cause) Due to (or as a cause) Due to (or as a cause) Due to (or as a cause)	consequenc	e of):					arrest,			Approximate interval Between Onset and Death Months
attending phy for use as th	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	I. 3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at til 9 ☐ Unknown	Fetal dea		opic pregnancy her (specify)	<u> </u>				23d. Date o Month		/ Day Year
been signed by the should be detached	ed by P	Part II. Other significant conditions con	stributing to death but	not resulting	in the under	tying cause giv	ren in Part	l.	23e. Did t				cause of death? oly 4 □Unknow
certificate has beerector, page 2 sho		ischemic cardionyo	cathy						24a Was auto perfo 1 🗆 Yes		dea	th?	sy findings availab pletion of cause of
After this certifuneral directo	on: To Be	27. Manner of Death 1 ⊠Natural 5 □ Pending	ospital: 1 Inpatient 28a. Date of Injury (Month, Day)		. Time of Injury	DOA Oth	er: 4 □ N y at k?	ursing Hor	n <i>(Check only c</i> me 5 ★ Resi 28d. Describe	dence		Specify)	
within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, (Specify)			Yes 2	- 1	28f. Location (: City or Tox			or Rural I	Route Number,
within 24 hours afte To the Funeral Dir completely filled in	Medical (29a. Certifier 1 Certifying Physical Check only 2 Medicel Exemination	sician: To the best of ner: On the basis of e and manner state	xamination a	ge, death occ and/or investi	curred at the tir igation, in my o	ne, date a pinion, de	nd place, a ath occurre	and due to the ed at the time,	cause(s date and	and manned place, and	er as stat due to t	ed. he cause(s)
within 2 To the complet	Me	29b. Signature and title of certifier Peashed Sh	de mo)		29c. Licens		0			te signed (A		ay, Year)
IVA		30. Name and address of person who co Prashant Shuk 31. Date filed (Month, Day, Year)	mpleted cause of dea	15 S.) (Type, Prin	e St. H	400	Aher	deen "	~ 0 2	100)		

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician March Cornish 2004 deraldine Catherine /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Darchester Dorchester General Hospital Cambridge
If Under 1 Year If Order 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Min. 1□M 2XF 215-20-0790 Yrs. Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Cambridge 1 Tes 2 No Maryland Dorchester Directo 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code USA 4714 Ea 21613 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ack 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Personal College (1-4or 5+) Elementary/Secondary (0-12) Home-maker 0-12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic access. 17. Father's Name (First, Middle, Last) Thomas Jefferson Vaughn Edith Raphe 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 Smr Circle Apt. 102 Oderston mp 21113
use of Disposition (Name of Date 20c. Location - City or Town, State arry W. Cornish, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State March 132004 Cambridge MD OldField Cemetery • 4 □ Donation 5 □ Other (Specify) Cambridge, MD2 Ke13 21. Signature of Funeral Service Licensee 22. Name and Addres of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Boardley Funeral Home 812 Hubbard St. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner n Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. [Diease of in hy that initiated events resulting in death) Last to (or as a consequence of): Examiner signed by the attending physician and ibe detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2/100 1 Yes To the Hospital or Attanding Physician: within 24 hours after death.

To tha Funaral Diractor: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No DOA 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Destrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B Camble AL s Signature 31. Date filed (Month, Day MAR 1 2004 Registra

Registrar

DHMH 17 Rev 1/2001

State

			For State Registrar	State of Maryland	d / Departr <i>Certifi</i>	ment of He	ealth and M Death		iene 200	4 10406
	Dhusioi	22	Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici /Medic	al	4a. Fecility Name (If not institution, give st	read and number	4h	City Town or	Location of Death	March	13 200 4c. County of De	
	Examin	ier	11. 1 011.1	and Medical Co	aten	Balt	more		,	
	Funeral		5, Social Security Number 6. Sex	7. Age (In yrs. I.	Mo	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey,	Year) (rthplace (Stete or Foreign Country)
	Director		577-48-3966 Usuel Residence of Decedent	68	3 Yrs.			Aug. 15	,1935 Was	shington, DC
	how		10a. State 10b. County	10c. City	, Town or Location	on				10d. Inside City Limits 1 ☐ Yes 2 🔀 No
:	8a-1 e	ecto	Maryland Anne Arun	ndel M	illersvi	11e Of, Zip Code		11	Og. Citizen of What (
	Sa or 3	1 Dir	10e. Street and Number 8301 Hope Point Cou	ırt	1	21108			U.S.A.	,
	death	Funeral Directo		Was Decedent Ever in U.: Armed Forces?	S. 13. Was	Decedent of His	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No-		nerican Indian, nite, etc.
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. He fleet is a retreated of the then "natural", or items 23s or 28s-f show other treumatic event, the Madical Examinations to inflied a	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □Yes 2X No If Yes, Give Year or Dates:	1 🗆	Yes 27 No	Specify:		Specify:	White
<u>ה</u>	natu natu	letec	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give kind	's Usual Occupa I of work done d VOT use retired;	luring most of work		16b. Kind of Busines Child	s/Industry
717	filed withir Hygiene. other then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Daycare				Car	2
	tal Hyg	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name			
Z Z	should be nd Mental marked o umatic eve	70	Frank 19a. Informant's Name/Relationship (Typ.	Kearn		ddrass (Straat a	Ernestin		M. City or Town, State	Maize
=	od 2 sho Ith and 27 is m treum		Norma L. Clark/ Day						ville, Ma	
ந	os 1 and 3 of Health item 27 other tr		20a. Method of Disposition		lace of Disposition	n (Name of ery or other place	g)		20c. Location · City of	or Town, State
EIIIO	Pages ment of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	-	tt Crema		3/18/		Waldorf, 1	
Dail	permit. Pages to Department of Himportant: If ite eny injury or of Once.		21. Signature of Fuperal Service License	e >					Evans Fun , Marylan	
	-nysician Medical Fxaminer hysician and hysi	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of):	homm	now ha ge			10 hours
O. Box 68	of the death certificate by the attending physicached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Wo 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	Ideath 3 ⊟Ect	topic pregnancy her (specify)			23d. Date of o Month	leilvery Day Year
2	be de	by Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the unde	rlying cause give	en in Part I.	1		to the cause of death?
ecords,	w require been si should I									
r	The ate h page	Completed						24a, Was a autops perform	ned? death	autopsy findings available o completion of cause of ? es 2 \square No
Vita	icien: certific ector.	Be	25. Was case referred to medical examiner?	lospital: 🏠	500 minut	Othe	26. Place of Deat			
ō	ding Phys n. After this funeral dir	lon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Pecident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	3 DOA 28c. Injun Work			ance 6 ⊡Other (S) ow injury occurred	outry)
Division	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif		factory, office		28f. Location (St City or Town		Rural Route Number,
	the Hospital or nin 24 hours afte the Funeral Dir npletely filled in	Medical C	29a. Certifier Check only one) Certifying Physical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death oction and/or invest	curred at the tin tigation, in my op	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License	e number	2	9d. Date signed (Mo	nth, Dey, Year)
ı			1/2/			17165	55/	/	lach 1.	32004
			20. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type, Pri	nt)	and 1	212	01 1/	16.6.1.
	St	ate	31. Date filed (Month, Dey, Year)	32. Redstrar's Signa	ature	wre IV	Lina	012	<u> </u>	in its singly
	Regist	trar	MAK 167	004	K A	make "				

		_	For State	State of Ma		/ Depa	artment o		and Me	ntal Hyg	iene ,	2004	101.07
			Registrar			Cei	lilicate	OI Deali		. Date of Deat	eg. No. [©] h	. 0 0 7	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last CLARA SMACH						2	Month 3	Day 12	2004	11:05A M
	/Medic		4a. Facility Name (If not institution, give			· · · · · · · · · · · · · · · · · · ·	4b. City. To	wn, or Location	of Death	<u> </u>		ounty of Death	11.03/
	Examin	er	The Friends		1		Berl				W	orceste	er
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. las	st birthday)	If Under 1		r 24 Hrs. g	Date of Birth (Month, Day, 9/22/1	Year)	9. Birth	place (State or Foreign
	Director		217-30-7702]M 2X(F 9	0	Yrs.	Working	Jays		9/22/1	913		" MD
	p .	-	Usual Residence of Decedent 10a, State 10b, County		10c. City.	Town or Lo	cation						10d. Inside City Limits
	sho	5				Berlir							1 ☐ Yes 2 X No
	the N 28a-1	Director	MD Worcest 10e. Street and Number	er		Derm	10f. Zip Co	ode		1	0g. Citize	n of What Cou	ntry?
	death with the Maryland rms 23a or 28a-f show r must be notified at	<u>a</u>	10433 Georgete	own RD				21811			U	SA	
	death ms 2	Funeral	11. Marital Status	12 Was Decedent 8	Ever in U.S.	. 13. \	Was Deceder	nt of Hispanic O	rigin? (Spec	ify Yes or No-	14	Race - Ameri	
	after or Ite	F.	1 ☐ Nøver Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔊	lo	1	1 ☐ Yes 💥				s	pecify: Wh	
2-003p	within 72 hours after death with the Marylan nne. han "naturel", or items 23a or 28a-f show e Medical Ezani ar must be notified at	d by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:								of Business/In	
<u>.</u>	"nati	iete	15. Decedent's Ed (Specify only highest grad	le completed)		(Give	dent's Usual (kind of work DO NOT use	done during mo retired)	st of working	,	100. Kirid	Of Business/iii	udostry
121		Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		les				Git	ft Shop	
Ö		Be C	17. Father's Name (First, Middle, Last)		,			18. Moti	her's Name (First, Middle, i	Maiden Si	umame)	
lan	0 2 0 9	To B	Elton D. Smack					Be	ertha	Richard	dson		
Maryland	d 2 should th and Men 7 Is marke treumatic		19a. Informant's Name/Relationship (7					Street and Num					
≥ ′	and 2 ealth m 27 I	L a	Walter Dennis	(Son)	20h Pla			rgetowi	n KD			21811 ation - City or T	
altimore,	ges 1 t of H If ite or ot		20a. Method of Disposition 1 XBurial 2 Cremation 3		cer.	netery, crer	natory or othe	metery				lin, MC	
	t. Pa rtmen rtent:		'4 □Donation 5 □ Other (Specify 21. Signatura of Fundral Service Licen		EVI								
Ba	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tt		14.12			22	108 Wi	Address of Fac Iliam Si	Burba Ber	ge Fun Jin Mi	eral	Home 1811	
			23a. Pa 11. Int. ue dise 1 e, or comp shock, or heart failure. List only	lication, that caused	the death.	Do not ent	er the mode	of dying, such a	s cardiac or	respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final	one causeron each iir	10. A 5		THI						Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as	a conseque							-	
	Examiner		Sequentially list conditions	B. PANC	REA	MIC	HA	4					
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):							
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):	•						
60,	e be executed sician and e burial-transit	aiE											
687	death certificate attending phys for use as the			d									
Box	n certi	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			⊒Ectopic preg	anancy			23	d. Date of deliv	
-	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at			Other (spec				10	Month	Day Year
0	Attending Physician: The law requires that the death certificate redeath. cotor. After this certificate has been signed by the attending physy the funeral director, page 2 should be detached for use as the	Physician/Medic	9 Unknown			A1 1 - A5		In Dear		23a Did to	hacco use	oontribute to t	the cause of death?
	igned be de	þ	Part II. Other significant conditions of	ontributing to death b	ut not resur	ting in the u	inderlying cau	use given in Par	t 1.			No 3□Pro	`
Records,	w requir been si should	eted								24a. Was a			opsy findings available
၁ဓင	e law has t je 2 s	Completed								autop: perfor	sy med?	prior to co death?	ompletion of cause of
a	n: Th ficate nr, pag		25. Was case referred to medical					26 Pla	ce of Death	1 Yes (Check only or	2DXNo	1 🗆 Yes	2 No
₹	sicial s certi irecto	To Be	examiner?	Hospital:	ent 2 🗆 E	R/Outpatie	nt 3 DOA	Other				Other (Speci	Assisted
ō	g Phy erthis eral c		27. Manner of Death	28a. Date of Inju (Month, Da	ry 2	28b. Time o		c. Injury at Work?	2	3d. Døscribe h	ow injury	occurred	Living
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Division of Vital	or Attendate death after death Director:	Certification:	3 Suicide 6 Could not be determined	286. Flace 01 111	ury - At hon c. <i>(Specify)</i>	ne, farm, st	reet, factory,	office	2	Bf. Location (S City or Tow		Number or Rur	al Route Number,
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		00 0 4/1- 24/1- 24	ysicien: To the best	of my baco	dodge de-	th aggregat at	t the time date	and place as	nd due to the o	alice/cl a	nd manner as	stated
	Hos 24 ho Fune stely f	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medicel Exer	niner: On the basis of and manner st	f examination	on and/or in	nvestigation, i	n my opinion, d	eath occurre	d at the time, o	late and p	lace, and due	to the cause(s)
	To the Hospitel within 24 hours a To the Funerel I completely filled	Me	29b. Signature and title of certifier	0. 0	(17	29c.	License numbe	r	. 2	29d. Date	signed (Month,	Day, Year)
)	~ > F 0		> W	gray,	H	1/	C	008	198		3-	16-1	04
ı.	,		30. Name and address of person who	completed cause of c	leath (Item	23а) (Туре	, Print)		Λ	0	1 1	C. B	artin, MO
ᅼ	.6		Lilah C. OCA	70162	M.D	1, 3	4 1/6	SOURCE	MC	IL .	te 1	14	21811
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 7 2	32 Aegisti	rar's Signati	1 A	review						

	1 - For State Registrar	State of Maryland	/ Department of F Certificate of	lealth and Me	ntal Hygiene	•	latas
Physician /Medical	1. Decedent's Name (First, Middle)				Date of Death Month Da March 9	ıy Yəar	3. Time of Death 12:00p ^M
Examiner	A = 10 A1 A1 A1 A1 A1 A1 A1	n, give street and number) ead	Oxon	r Location of Death Hill	4c	County of Deeth	eorge
Funeral Director	5. Social Security Number 218-03-8669 Usual Residence of Decedent	6. Sex 7. Age (In yrs. las	t birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Year, July 6,1	9. Birthol Coun. 918 Mar	ece (State or Foreign try) yland
the Maryland 28a-1 show nutities at	10a. State 10b. Count		Town or Location on Hill 10f. Zip Code		10g. Ci	tizen of What Coun	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
be filed within 72 hours after death with the Maryland hall Hygiene. Id other than "natural; or items 23a or 28a-f show event, the Medical Exardirat; and be notified at the Commission of the Financial Director.	3 ∰Widowed 4 ☐ Divorce	12. Was Decedent Ever in U.S. Armed Forces? 194	2074	dispanic Origin? (Specif an, Mexican, Puerto Ric	τ	J.S.A. 14. Race - America Black, White, 6 Specify: Bla	an Indian, atc.
d 2 should be filed within 72 hours af the and Mental Hygiene. 77 is marked other han "natural; or traumatic event, the Medical ExempTo Re Commissed hygiens.	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Laborer		U.	S. Gove	
	Lemuel	Dent		18. Mother's Neme (F	Gaine	s	
permit. Pages 1 and 2 should Department of Health and Mer Important: If item and night of the straumatic any nighty or other traumatic once.	19a. Informant's Name/Relation Gale Head 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 4 □ Donation 5 □ Other (21. Signature of Funeral Service)	DAughter 3 □ Removal from State Specify) DAughter 20b. Placenter Com. Mar	19b. Mailing Address (Street 6533 Bock F se of Disposition (Name of netery, crematory or other plan cyland Veter 22. Name and Addre Willian	Rd., Oxon	Hill, M. 20c. L 5,2004 cery Ch	Id. 2074 ocation City or Total	5 wn,State m, Maryla
Physician /Medical Examiner	23a. Part1. Enter the disease, shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Securities list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	or complications that caused the death. It only one cause on each line.	Do not enter the mode of dyir nea of):	ng, such as cardiac or re	a., Indi		Md. 206. Approximate Interval Between Onset and Death Clarin
eath certificate be attending physicis for use as the but he at the but	<u> </u>	d. 23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal de 4 Pregnant at time of deal	eath 3 Ectopic pregnancy	,		23d. Date of deliver Month	y Day Year
wrequires that the deben signed by the should be detached	a Partiti Striet significant sonia.	ions contributing to death but not resulti	ing in the underlying cause giv	en in Part I.	23e. Did tobacco	use contribute to the	,
The law requale has been page 2 shou	D D D D D D D D D D D D D D D D D D D				24a. Was an autopsy performed?	death?	sy findings available ipletion of cause of
or Attending Physicien: The law requires that the dafter death. Director: After this certificate has been signed by the fin by the funeral director, page 2 should be detached to by the funeral director.	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 EF	8b. Time of 28c. Injury Wor	y at 280	Check only one) 5 Residence I. Describe how inju)
tal or Attending P s after death. al Director: After ted in by the funers	Suscide 6 Could	not be a 28e. Place of Injury · At hombuilding, etc. (Specify)	e, farm, street, factory, office	28f	Location (Street ar City or Town, State	nd Number or Rural e)	Route Number,
To the Hospital within 24 hours to the Funeral completely filled	29a. Certifier (Check only 2 Medical one)	ng Physician: To the best of my knowle I Examiner: On the basis of examination and manner stated.	n and/or investigation, in my o	pinion, death occurred	at the time, date an	d place, and due to	the cause(s)
To with	· EA.	who completed cause of death (Item 2		470490		Ite signed (Month, E	vay, 1841)
State Registrar	Elizabeth L 31. Date filed (Month, Day, Yea	indentercer MI	116	D.C. VA Me	d(+v 50)	Erving St	NW 2045

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 () () [1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth March 13, Day 2004 **Physician** Mary EmilyDiToto 9:30 A /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Prince George's Fort Washington Hospital Fort Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral Months Days Hours 1□ M 2 7 94 Yrs. 577 60 5072 Director June 13. 1909 Washington DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health end Mantal Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at page. 1 ☐ Yes 2√ No Funerai Director Maryland Prince George Camp Springs, 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 4623 West Ridge Place 20748 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give XX 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1□Yes 2□No Completed by Specify. 3√Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Acqusition Purchasing Agent | Navy Dept. 12 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Lucy (Unknown) Alexander Marucci 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (SON) Paul DiToto 12713 Old Marlboro Pike, Upper Marlboro, MD 20772 20b. Place of Disposition (Neme of cemetery, crematory or other place) March 17, 2004 20a. Method of Disposition MSBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licenses Alexandria Ferry Road, Clinton, Maryland 20735 MOUGO Talles 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last end Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings 24a. Was an autopsy available prior to completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 1. Inpatient 2 □ ER/Outpatient 3 □ DOA this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No r daath. I Director: And in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner steted. (Check only 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of certifier 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) MRAM sistrar's Signature 31. Date filed (Month, Day, MAR State 2004 Registrar

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			Registrar			061	incate of	Dean		Date of Deat	<u> </u>	3. Time of	of Death
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1215-UU36 / W. Within 72 hours after death with the Maryland one.	d other than "natural", or fems 23s or 28s-1 snow event, the Medical Examinar must be multified at	be	15. Decedent's E		1	16a. Dece	dent's Usual Occu	pation			16b. Kind of Busi	ness/Industry	
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Maryland 212 d 2 should be filed withir th and Mental Hygiene.	7 is marke traumatic	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street	t and Numi	ber or Rural F	Route Number,	City or Town, St	ate, Zip Code)	
	N - 1		HARVEY J. DAVIS/S	NC		5652	BEACH HA	VEN R	ROAD, E	AST NE	W MARKET	, MD 216	31
6 , − ₹	tem othe		20a. Method of Disposition		20b. Plac	ce of Dispo	osition (Name of matory or other pla	ace)	Date	e 2	20c. Location - Ci	ity or Town, State	
MOF Pages	, it: #		1 🗓 Burial 2 □ Cremation 3 💆 4 □ Donation) 5 □ Other (Specif		-		UMC CEM.	- 1	3/7/20)04 N	EWARK, I	ELAWARE	
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s that	pe del	y P	Part II. Other significant conditions	contributing to death b	out not result	ing in the u	ındariying cause gı	iven in Pari	t I.	23e. Did tob	acco use contrib	ute to the cause of	death?
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<u>a</u> <u>a</u>	tifica tor, p	Be C	25. Was case referred to medical	- 000	100	,,,,	Ha	26. Pla	ce of Death (Check only on			
ysici <	is cer direc	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatio	ent 2 El	R/Outpatie	nt 3□ DOA Ot	ther: 4	Nursing Home	5 🗆 Reside	nce 6 Other	(Specify)	
O 4	er th		27. Mann of Death	28a. Date of Inju (Month, Da	iry 2	8b. Time o	of 28c. Inju	ury at	28	d. Describe ha	w injury occurred	1	
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Di Hospital or 24 hours afte	To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	edical		nysician: To the best miner: On the basis of									(s)
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To with	000	Σ	29b. Signature and title of certifier	1 Hola	~/ n	MA	29C, Licen	nse number	2719	> 2	ed. Date signed (Month, Day, Year)	
			· Will	avn 11 WO	vay.	1-16					0/5	707	
			30. Name and address of person who		_				14 amer	VC 01	(01		
			WILLIAM H. WOOD,						LASTON,	MD 21	pUI		
	Sta	ite	31. Date filed (Month, Day, Year) MAR 0	8 2004 L	Gallage a	K	Such						

			1 - For State of Maryland / Department	rtment of Health and M	lental Hygien	
			1 Decedent's Name (First, Middle, Last)	modeo or boatin	2. Date of Death	3. Time of Death
	Physici /Medio		Robin TRESSY Douglas		Month Da	
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	44	c. County of Death
			21 Jomes COUE APT.	(Ristield		SomeRSET
*	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)
	Director		219-74-9175 Usual Residence of Decedent		11-26-6	3 1410
	how		10a. State 10b. County 10c. City, Town or Local			10d. Inside City Limits
	Ba-f s	cto	MD SOMERSET CRISTIC	etd		1 A Yes 2 No
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23s or 28s-f show or other traumatic event, the Medical Examinar must be natified at	by Funeral Director	21 Somes Cove Apt.	10f. Zip Code 817	10g. C	itizen of What Country?
	ema ema	Iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
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Je,	of Health of Health filam 27 r other tr		20a. Method of Disposition 20b. Place of Disposi	tion (Name of Datory or other place)		ecation - City or Town, State
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Baltimore	permit. Pages 1 and Deportment of Health Important: If item 27 any injury or other tr		21. Signature of Funeral Service Licensee	Name and Address of Facility	uneral Hen	
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac o		Approximate
M	Physician		Immediate Cause (Final disease or condition	me FAIL	1300	Interval Between Onset and Death
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	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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Вох	leath certifica attending ph I for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	·		23d. Date of delivery
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of V	S S D	70	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient		ne 5 Residence	6 □Other (Specify)
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Division	in Sir e	Certification:	4 Homicide determined determined building, etc. (Specify)	at, ractory, office	City or Town, State	e)
	To the Hospital or Attenc within 24 hours after death To the Funeral Diractor: completely filled in by the	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the control of the properties of examination and/or investigated.	occurred at the time, date and place, a stigation, in my opinion, death occurre	and due to the cause(s and at the time, date an) and manner as stated. d place, and due to the cause(s)
	To th within To the comple	Me	29b. Signature and title of certifier	29c. License number		ite signed (Month, Day, Year)
			Musellesus MD	D-5781		3/22/2004
			30. Name and address of person who completed cause of death (frem 23a) Type, Pr	ighusy CR	SFIEL	3/22/2004 0, MD 21817
2	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 4:		
Uhi	Registr MH 17 Rev 1/2		MAR 2 2 2004 Steen &	gones		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 19:10+ March 2004 /Medical 4a. Facility Name (If not institution, give street a 4b. City, Town, or Location of Death 4c. County of Death Examiner NICOMICO SALISBUM CONTE Medical KIGIONA TENINSULA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 200 F Days Hours Months Z 27-20-3549 Usual Residence of Decedent Director -10-10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "naturel", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 PYes 2 □ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Hhans Funerai 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 28 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than mentary/Secondary, (0-12) College (1-4or 5+) Hygiene. 10th grade Ker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 Is marked o 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) rand mo Ke 20b. Place of Disposition (Name of cemetery, crematory or other place) DINA 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □Removal from State injury or 4 □Donation 5 □ Other (Specify) (encitor 22. Name and Address of Facility Bennie 21. Signature of Funeral Sec. eny ir Homo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Aut Rend **Physician** Farly /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a cons y uence of Examine and Due to (or as a consequence of): physician a the burial-Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) n signed by the a ld be detached f o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Durk Milis 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy perforn 25. Was case referred to medical examiner? certificate 1 Yes 2 No Vital filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funerel Dire 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DYYOLA 3.4.2004

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person

times a

31. Date filed (Month, Day, Year) MAR 0 9

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21804

n who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signature

2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Ennals 03 405 AM 6 Vons 04 11 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medizal Center Baltmore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1□M 2 F **Funeral** Months 218-20-3140 Usual Residence of Decedent 27,1928 Director 218-20-Maryland the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itema 23a or 28a-f ehow 1 Yes 2 No Dorchester Funeral Director Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. 21613 deeth v 1000 Maces iane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 P No Specify Specify: Black þ 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Food Processing Production-Line Worker 10 Department of Health and Mental Hygie Important: If item 27 is marked other tany injury or other traumatic event, IL once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Pages 1 and 2 should be ပ Lakence Navgaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Aval Route Number, City or Town, State, Zip Code) Cambridge Mary land 21613
Date 20c. Cappin - City or Town, State = nna l 000 Maces Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) . Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State Cemetery 3/16/04 Trappe, Maryland Paradise * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HENRY Funeral Home, P. A. Party Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD. 21613 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Metastatic adeno (grinoma 12 Craws resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for Examiner physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed Occlusion Due to (or as a consequence of) Box 68760, Physician/Medicai the attending IE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 1 Yes 2 No 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐ Yes 2 No After this certificate 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 Inpatient Other: 1 Yes 2 No Medical Certification; To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of D am 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours at To the Funarat D completely filled a the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P14550 30. Name and address of person, who concluded cause of death (Item 23a) (Type, Print)

State Registrar

anne

31. Date filed (Month, DaMAR 15

659

2002 Register's Signature

Baltomare

			For	State of Maryla	and / De	partment of	Health and	Mental Hy	giene		
			1 - State Registrar		С	ertificate o	f Death		Reg. No	2001	+ 10416
}	Physici /Medic	al	1. Decedent's Name (First, Middle, Last, RAYMOW) GR 4a. Facility Name (If not institution, give	IBBEN.	JR	Ab City Tourn	or Location of Dea	2. Date of De Month	Da 7	Year 200	4 11:40 P.M
	Examir	ier	BALTIMORE REHABILITY		D CAPE	5 40. Oily, 10wii,	BALTI	more	40	. County of De	eur
	Funeral Director		547-74-0941	7. Age (In yi	rs. last birthda 49 Yrs.	Months Day			th y, Year) , 19	9. B 9. B Wa	irthplace (State or Foreign Country) shington, D.(
	aryland show	-	Usuel Residence of Decedent 10a. State 10b. County	10c.	City, Town or	Location					10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	the M	recto	Maryland Cecil 10e. Street and Number	Per	ry Poi	.nt 10f. Zip Code			10a, Cit	izen of What (
	th with	al Di	1181 4th Street			21902			USA		,
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is merked other then "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1972		3. Was Decedent of If Yes, specify Cu		Specify Yes or No rto Rican, etc.)		14. Race - An Black, Wr Specify: Wh:	ite, etc.
Maryland 21215-0036	2 hour	ted k	15. Decedent's Edu	cation	16a. De	cedent's Usual Dcc	upation		16b. K	ind of Busines	1te s/Industry
215	ithin 7	Completed	(Specify only highest grad	College (1-4or 5+)	life	ve kind of work don . DO NOT use retii	e during most of wi red)				
d 21	Hygiel Hygiel other ti	CO	12 17. Father's Name (First, Middle, Last)		Mech	anic	18. Mother's Na	ame (First, Middle,			r Conditionir
au	Mental rked o	To Be	Raymond Leonard Gr	ibben, Sr.				t Trimble		,	
lary	2 should I and Men is marker aumatic		19a. Informant's Name/Relationship (T)	pe, Print)	19b. Ma	iling Address (Stree	at and Number or F	Rural Route Numbe	r, City o	or Town, State,	Zip Code)
	1 and Health em 27 ther tr		Thomas A. Gribben/ 20a. Method of Disposition	brother		Carlisle		larksvil.		MD 2102 ocation - City of	
JO.	ages ant of nt; If it		1 ☐ Burial 2XX remation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)			position (Name of rematory or other pi Crematory	7	ch 10,			
Baltimore,	permit. Pages 1 an Department of Heal Important; If item 2 any njury or other once.		21. Signature of Funeral Service Liceny	944		22. Name and Add	ress of Facility	on Servi	20	D O B	Maryland ox 784
4	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	HEPATO CE		AR CAP			rest,	LNSVAL.	Approximate Interval Between Onset and Death
	Examiner	Jer.	Sequentially list conditions, if any, leading to immediate	HEPATIT Due to (or as a cons	15 C						il years
68760,	ate be executed nysician and he burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
BOX	ath certifica ittending pl or use as t	by Physician/Medi	in the past 12 months?	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	ital death	EEctopic pregnan	су		4	23d. Date of de Month	elivery Day Year
7. O	uires that the de n signed by the a ld be detached f	y Phy	9 ☐ Unknown Part II. Other significant conditions con		esulting in the	underlying cause g	iven in Part I.	23e. Did to	bacco u	sa contribute I	to the cause of death?
SDJ	w requires been sig should be							1 🗆 Y	es 2[□No 3□P	robably 4 Unknown
Vital Records,	sician: The law re certificate has be irector, page 2 sho	Completed						24a. Was a autop perfor	sy	prior to death?	utopsy findings available completion of cause of s 2 \square No
	sician certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Mnpatient 2	☐ ER/Outpati	ent 3 DOA	thor	ath (Check only or		7 (7)	
DIVISION OF	To the Hospital or Attending Physician: The within 24 hours after dash. To the Funeral Director: After this certificate his empletely filled in by the funeral director, page	\vdash	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Inju		Home 5 Resid			ecity)
DIVIS	ial or Atte s after de al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, : cify)	street, factory, office)	28f. Location (S City or Tow			ural Route Number,
	To the Hospita within 24 hours To the Funeral completely filled	Medical (29a. Certifier 1 Certifying Physical Control 2 Medical Examination	sician: To the best of my kner: On the basis of examinand manner stated.	nowledge, de nation and/or	ath occurred at the tinvestigation, in my	time, date and plac opinion, death occ	e, and due to the c urred at the time, d	ause(s) late and	and manner a place, and du	s stated. e to the cause(s)
	To th To th	Me	29b. Signature and title of certifier	1	L 10	29c. Licen	ise number	7 2	29d. Date	a signed (Mon	th, Day, Year)
, ,	8		Aurora C	lan, 1	hie U	· D	14458	M	APC	H 8,	2004
X	02		30. Name and address of person who co	mpleted cause of death (It	əm 23a) (Typ	e, Print)	WARD BI	ALTINUTE	= 1	10 21	218
	Sta Registr	70	31. Date filed (Month, Day, Year) MAR 1 0 20	04 32. Angistrar's Sign	nature	Sparles			(<i>y</i>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 10417 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 08:36 AM ANNIE L. HOLDEN March 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore
if Under 1 Year | If Under 24 Hrs. Good Samaritan +05pital Date of Birth (Month, Day, Year) 06/06/1915 9. Birthplace (State or Foreign Country) Virginia 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F 88 215-32-0018 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State itam 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic avant, the Macical Examiner sust be notified at **Baltimore** 1X Yes 2 □No MD Baltimore Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 4800 Yellowood Ave., Apt. 709 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married **Black** 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 5 Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Laborer Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Carrie West Pettit James Pettit 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CAtherine Hargis, Cousin 4917 Lanier Ave., Apt. A Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o ō 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Household of Ruth 03/14/04 4 ☐ Donation 5 ☐ Other (Specify) Accomac, VA 21. Signature of Funeral Ser 22. Name and Address of Facility P.O. Box 176 Accomac, VA 23301 Cooper & Humbles Funeral Co. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sa uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No Division of Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation vithin 24 hours after death.

To the Funerel Director: After the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Res 000 March 11, 2004 escure 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Annie Holden

32. A gistrar's Signature

Astsaturov

MAR 15

31. Date filed (Month, Day, Year)

Loch Raven Boulevard, Baltimore, MD 21239

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** March Misto 200 ohe /Medical 4b. City, Town, or Location of Death 4c. County of Death ta. Facility Name (If not institution, give street and number) Examiner Medical Syste Ba If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Feb. 25, 1950 Yrs Maryland Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Example in the notified at once. 1 Yes 2 No Director ambridge 10f. Zip Cod 10g. Citizen of What Country? 10e. Street and Number 21613 405 Street Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Dayes 2 No 1969 If Yes, Give Year or Dates: 1971 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) County Public School Custedian 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Nichols Virginia Livonia He
19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Franklin Nichols ၉ SECRGE 19a. Informant's Nam elationship (Type, Print) 20b. Place of Disposition (Name of cambridge Maryland 2 Date 20c. Locatin - City or Town, Stete Collins 20a. Method of Disposition HENRY 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Vieterans Cemetery 3/ 22. Name and Address of Colliny 122/04 HURIOCK, * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Henry Funeral Home, P. A. 510 Washington St. Cambridge 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immedia Cause (Final disease or condition resulting in death)

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed **burial-transit** and Due to (or as a consequence of): Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year 5 Month Day 5 Other (specify) been signed by the a should be detached f Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 🗖 No 3 ☐ Probably 4 ☐ Unknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an s certificete has t irrector, page 2 s autopsy performed? Yes 2 No 1 Yes of Vital within 24 hours after death.

To the Funarai Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 \(\sqrt{Inpatient} \) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification; 1 Natural Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day MAR 2004 Registres Signature State Registrar

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			For State	State of Maryland				-		1 101 10
			Registrar		Cer	tificate of I	Death		Reg. NaZ U ()	
	Physici /Medio	_	1. Decedent's Name (First, Middle, Last) Margaret E	. Humler				2. Date of Dead Month	- 4	(ear 9 56 A M
	Examin		4a. Facility Name (If not institution, give s	reet and number) Nedical Car	fer	4b. City, Town, or	Location of Death	, ,	tc. County of	-Arudel
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) 04-13-		B. Birthplace (State or Foreign Country) New York
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	cation				10d. Inside City Limits
	the Mar 28a-f at cutified	Director	Maryland Anne Ar	undel	Ri	Va 10f. Zip Code			10g. Citizen of Wh	1 ☐ Yes 2 📆 💢 to
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	me 2	Funeral		Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Race -	American Indian,
920	72 hours after death with the Maryland natural; or teme 23a or 28a-f ahow disal Esaribier must ke noilified at	Ď	1 ☐ Never Married 2 ☐ Married 3 😾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes 2X No	Specify:	o ritoan, etc.)	Specify:	White etc. White
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ylaı	should be and Mental marked o	P	Edward Joseph	Daly			Mar	y Agnes	Cox	
Maryland	and is m		19a. Informant's Name/Relationship (Typ						r. City or Town, St	
	item 27		Paul E. Humler/ So 20a. Method of Disposition	20b, Place	e of Dispos	sition (Name of		Date Riva	MD 2114	
Baltimore,	e ° ± 5		1 Daurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State St. 7		cemetery		3-04	Menands,	
alt:	그 든 은 글		21. Sign was of Funeral Sen ce License		22	. Name and Addres	ss of Facility Go	orae P	Kalas Fr	neral Home
ä	Depa Impo any ir		10/10 Clel							, MD 21037
	Physician		23a. Pan1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	ations that caused the death. De cause on each line.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
8760,	physician and purial-transit	lical Examiner	Sequentially list conditions, it any, reading to immediate cause. Enter Underfloar Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ce of):	litation	from	resal!	tal ove	- years
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COL	w require been si should t	lete	(decess:					24a. Was a	an 24b. We	re autopsy findings available
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		F	27. Mann Death	28a. Date of Injury 281	b. Time of	28c. Injury	at		ence 6 Other ow injury occurred	
ion	Attending F r death. sctor: After by the funera	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 🗆 '	Yes 2 □ No			
Division	al or Attences after death	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	cian: To the best of my knowled er: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occur	and due to the or red at the time, o	ause(s) and mann late and place, and	er as stated. If due to the cause(s)
	To the within 2. To the Complet	Me	29b. Signature and the of certifier			29c. License	number	2	29d. Date signed (I	Month, Day, Year)
)			MACI	, MD		D:	58927		3/7/0	, ~
			30. Name and address of person who cor	npleted cause of death (Item 23	(Type, I	Print)	(2001	Medica	il Parking
			31. Date filed (Month, Pay, Year)	- (The Ital	N	redical C	enter	Annchy	is, MO	, 2,401
	Sta Registi		MAR 0 9 200)4		mak)				

State of Maryland / Department of Health and Mental Hygiene 2004 10420 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23^{Day} March **Physician** 200⁴4ar Abu Zafar M. Anwarul Hafiz 5:50P. M /Medical 4e. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 18, 1946 Birthplece (State or Foreign
Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 □ F 58 Bangladesh Yrs. 216-55-0870 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or frems 23s or 28s-f show the Medical Examiner must be notified at Silver Spring 1 Yes 2 No Maryland Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20903 10120 New Hampshire Avenue, #112 Bangladesh death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Asian Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Foreman Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Mohammad Ibrahim Asia Ibrahim 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20903 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is sny injury or other trau once. Monwara Hafiz -wife 10120 New Hampshire Avenue, #112 Silver Spring, Md. 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) George Washington Cemetery 3/24/2004 Adelphi, Maryland 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licensee torald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Stroke /Medical Due to (or as a consequence of) Examiner Parkinsons Disease Sequentially list conditions, I arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Records, P.O. Box 6876 Completed by Physician/Medical as the esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Pe 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Shy Drager Syndrome 1 Yes 2 No 3 Probably 4 WUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 X No Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funerel Director: After 5 Pending 1 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arastoo Yazdani, M.D. 9801 Georgia Avenue, #3-35 Silver Spring, Maryland 20902 32. Registrar's Signature 31. Date liled (Month, Pay, Year) State Registrar 1 2004 I SHOW

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	artment of H			ene a. No. 200	4 101.21
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
П	Physici		Sarahann	К	Hei	rtzler	J	Month anuary 1	2 2004 Year	4:30 P. M
	/Medic Examin		4a. Facility Name (If not institution, give s				r Location of Death		4c. County of De	
			36288 Bethel Church	n Road		Mechan	icsville		St. Mary	7 ' s
	Funeral Director		5. Social Security Number 6. Sex 1□	7. Age	(In yrs. last birthday) 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 2-2-200	9. B 3 Cal	inthplace (State or Foreign Country) LVert
	D >		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	sho	5	MD St. Mary			icsville				1 Tes 2 No
	28a-f	Director	10e. Street and Number	5	Mechan	10f. Zip Code		100	g. Citizen of What C	Country?
	with 3a or			. D1						,.
	ms 2:	Funeral	36288 Bethel Church	2. Was Decedent Ev	ver in U.S. 13. V	Vas Decedent of H	ispanic Origin? (Sp.	ecify Yes or No-	USA 14. Race - Am	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinal mail the righted at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		ryes, specny Cuba 1□ Yes 2√⊡ No	an, Mexican, Puerto Specify:	Hican, etc.)	Black, Wh	
21215-0036	thou stura	edt	15. Decedent's Educ	cation	16a. Deced	tent's Usual Occup	ation	16	5b. Kind of Busines	
75	nin 72 In 'na	Completed	(Specify only highest grade	College (1-4or 5+	(Give	kind of work done of DO NOT use retired	durina most of work	ng		,
2	giene giene er tha	mo.	Elementary/Secondary (0-12) N/A		<u>′</u> (Child			Child	
	al Hy d other	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	aiden Surname)	
yla	should be land Mental I s marked o	2	Tobias D. Hertzler					. Stoltz		
Maryland	2 sh and is m	0.5	19a. Informant's Name/Relationship (Type				and Number or Rura			
ď	1 and 2 Health is tem 27 is		Tobias D. Hertzler 20a. Method of Disposition	: (father)	36288 20b. Place of Dispos		Church Rd		sville, M.	
סַר	nt of h		1 Burial 2 □ Cremation 3 □ Re	emoval from State	cemetery, cren	natory or other place	(8)			
Baltimore,	it. Partiment pritant injury	1	*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licence		Hertzlery	Cementar	y 1-14-	2004 Me	chanicsvi	lle, Md
Ba	permit. Pages 1 and Department of Heali Important: If Item 2 any injury or other ance.		Dorra see	Brok	e P.	.0.Box 31	3 Leonar	Mary's C dtown, M	ounty Hea aryland	alth Departme 20650
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	eations that caused to e cause on each line	he death. Do not ente	er the mode of dyin	g, such as cardiac o	or respiratory arres	t,	Approximate Interval Between
	Pnysician	Y Y	Immediate Cause (Final disease or condition	Cardiop	ulmonary A	Arrest				Onset and Death
) SA	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
		L.	Sequentially list conditions, b	Trisomy	- 18					
	ped lisit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or).					
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189	ificate g phy as the	0								
Box	eath certific attending p	by Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of 1 ☐ Live birth 2)Catania asa asa asa			23d. Date of de	alivery
	ne deat the atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at ti		Ectopic pregnancy Other (specify)			Month	Day Year
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	signed d be del	by	Part II. Other significant conditions con	tributing to death but	not resulting in the ur	nderlying cause give	en in Part I.			to the cause of death?
ord	w requir been si should	ted						1 🗆 Yes	2X No 3 □ P	robably 4 Unknown
e C	e law e has b	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
	: The	Cor						performe 1 ☐ Yes 21	ed? death? ☐ No 1 ☐ Ye	
Vital Records,	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth	26. Place of Death			
	Phys this ral dir	2	1 Yes 2 No	1 Inpatient		t 3 DOA 28c. Injun	er: 4 Nursing Ho	me 5 🖄 Residence 28d. Describe how		ecify)
O	ding I h. After funer	tion	1 ☑Natural 5 ☐ Pending	(Month, Day	Year) Injury	Worl	k? Yes 2 □ No	LOG. Describe now	injury occurred	
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2	al or A after I Dire d in b	Certification:	4 Homicide determined	building, etc.	(Specify)			City or Town,	State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	Medical C	(Check only 2 Medical Examin	ter: On the basis of e	my knowledge, death	occurred at the time restigation, in my of	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner state	∋ a.	29c. License			. Date signed (Mon	
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7					they	D282	90		3/29/	07.
6.			30. Name and address of person who con Amardreet S. Dhillo				Loonsede	orm Marc	rlasi oo	650
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar		2	Leonardt	own, Mary	yrand 20	650
*.	Registr		MAR 29 20	04 1000						

			For State Registrar	State of Ma	ıryland	-	irtment of H <i>tificate of L</i>			giene Reg. No. 2 (
	Physici /Medic		Decedent's Name (First, Middle, La Delmas Sa	amuel John:	son				2. Date of De Month March	Day	3. Time of Disath. 2.
	Examin Funeral Director			Hospital		ast birthday). Yrs.	4b. City, Town, or Berlin If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March	th y, Year)	
•		tor	Usual Residence of Decedent 10a. State 10b. County MD Worce			, Town or Lo	cation		, mar cri	,	10d. Inside City Limits 1 Yes 2 XNo
	th with the 23a or 28a	Funeral Director	10e. Street and Number III07 Grays Corr	ner Rd.			10f. Zip Code 218	I		10g. Citizen of V	What Country?
920	72 hours after death with the Maryland 'naturel', or Itams 23a or 28a-f show Alsal Examinations Learselliand at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cuba Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		e - American Indian, ck, White, etc. c:White
Baltimore, Maryland 21215-0036	en 2 (34	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-	+)	(Give I life. E	ent's Usual Occupa kind of work done of NOT use retired,	ation furing most of work.)	ing	16b. Kind of Bu	siness/Industry Store
yland 2	parmit. Pagas 1 and 2 should be filad withir Department of Health and Mental Hygiene. Important: If item 27 Is marked other then any injury or other traumatic event, ITE Mone.	To Be C	17. Father's Name (First, Middle, Last Charles W. Johr	nson			•	18. Mother's Name Emma Ti	ngle		
e, Mar	and 2 sho lealth and m 27 Is m		19a. Informant's Name/Relationship	•		11107	Grays Co	orner Rd	., Beri	in, Md.	21811
timore	it. Pagas 1 rtment of H rtant: If ite njury or ot		20a. Method of Disposition 1	fy)	1	nset M		ark 3-14-		Berlin,	City or Town, State
Ba	parmi Depa Impo any ir		23a. Part. Enterthe disease, or con	maje	the death		8 William	s of Facility age Fune St., Be	rlin, Mo	d. 21811	Approximate
•	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. MALNUTF Due to (or as a	e. Loonsequ	ence of):	i the mode of dying	, such as cardiac C	о геориалогу аг	1651,	Interval Batween Onset and Death
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e/mes per 13/5' be			ADVANCED AGE						24a. Was autop perfor 1 🗆 Yes	an 24b. W sy p rmed? d 212 No 1	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2☐ No
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Johnson 216-09 Division of	To the Hospitel or Attending Physicien: within 24 hours after death. To tha Funaral Director: After this certific completely filled in by the funeral director.	Certification; T	27. Manner of Death 1 Valural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			28b. Time of Injury	28c. Injury Work M 1 \(\triangle Y	at 2 ? ′es 2 □ No	28d. Describe h	ow injury occurre	ed .
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	he Hospitel in 24 hours a ha Funaral I pletely filled	Medical	29a. Certifier 1 1 2 Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the best of miner: On the basis of e and manner stat	examinati	rledge, death on and/or inv	occurred at the timestigation, in my op	e, date and place, a inion, death occurre	and due to the o	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	Um			29c. License D005 6		2	29d. Date signed	(Month, Day, Year)
CI	4.6		30. Name and address of person who ADAM W. Ellis	MD	MT?	ANTIC	GENERO	il Hospi-	tal,	Berlin	, mD 21811
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	2004 32. Figistrar	r's Signati	of A	nade				

			1 - For State Registrar	State of Maryland	/ Department of Health Certificate of Deat		2000	10423
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give	Jen Ki	4b. City, Town, or Location	2. Date of Death Month Mair Ch	Day Year 02 200 5 4c. County of Deat	3. Time of Death 4:20PM
	Funeral Director		Mallard Bay 5. Social Security Number 17-07-8886 Usual Residence of Decedent	Care Cen YM 20 F 7. Ago (In yrs. last 92	ter (ambr birthday) If Under 1 Year If Under Yrs. Months Days Hours	er 24 Hrs 8. Date of Birth		ester place (State or Foreign untry) ur Yland
ことろ	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Asal Exaculant cust be recified at	rai Director	10a. State 10b. County MD Dorch 10e. Street and Number 1049 Camelia	circle	Cambridge 104. Zip Code 2/6/	3	Citizen of What Co	10d. Inside City Limits 1 Des 2 □ No untry?
2-0036	72 hours after de natural', or Itams	ted by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ② No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 ☐ Yes 2 ☑ No Specifi 6a. Decedent's Usual Occupation	an, Puerto Rican, etc.) y:	14. Race - Amer Black, White Specify:	c.K
2121	o filed within I Hygiene. othar than "	Be Completed by	(Specify only highest grade Elementary/Secondary (0-12) (2) 17. Father's Name (First, Middle, Last)	completed) College (1-4or 5+)	(Give kind of work done during mo life. DO NOT use retired) Warehouse - W	ost of working	od-Proce	
, Maryland	d 2 should th and Mer 7 Is marke traumatic	Tof	James Andrew 19a. Informant's Name/Relationship (Ty. Vanessa	5harp	19b. Mailing Address (Street and Num. 762 - CORNISH	Maggie Jo ber or Aurar Aboute Number, Ci DRive Camb	14.1	p code) Naky /and
Baltimore	permit. Pages 1 and Department of Healt Important: If Itam 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	emoval from State	a of Disposition (Name of etar), crematory or other place) + CWN CEME + ERY 22. Name and Address of Jaco	3/7/04 C	. Location of on T	
	Physician		23a. Part 1. Enfer the disease, or complishook, of heart failure. List only on Immediate Cause (Final disease or condition	cations that ceused the death. De cause on each line.	510 Washing	tow St. Camb	ridge M	D. 2/6/3 Approximate Interval Between Onset and Death De 48
	/Medical Examiner	niner	resulting in death) Saquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent Chyonic LES Due to (or as a conseq e Severe Peri	V doot wice,	- d		months
,0928	icate be executed physician and s the burial-transit	edicai Examiner	that initiated events resulting in death) Last	Due to (or as a consequent		differe		yen
P.O. Box 6	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death 9☐Unknown	ath 3 □Ectopic pregnancy		23d. Date of deliv	ery Day Year
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-	ਦੂ ≑ ਭ	Certification; T	27. Manner of Death i Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		o. Time of 28c, Injury at Work? M 1 ☐ Yes 2 ☐	28d. Describe how in	njury occurred and Number or Rum	
	To the Hospital or Attanding is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	one) A Medical Examin	ician: To the best of my knowled er: On the basis of examination and manner stated.	ge, death occurred at the time, date a and/or investigation, in my opinion, de	nd place, and due to the cause ath occurred at the time, date a	o(s) and manner as s and place, and due to	tated. o the cause(s)
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DIVI	H 17 Rev 1/20		12	1				

Physic	ian	1 - State Amend & Unp Registrar 1. Decedent's Name (First, Middle, L	Robert B.	Jewett	rimouto or		2. Date of Death	No. 2001	3. Time of Death
/Medi			tt, Jr.				March 14		850 a
Exami	ner	4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or Severna	Location of Death		Anne Aru	
		715 Shore Road 5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth		
Funeral Director		219-78-8304 Usual Residence of Decedent	1 ⊠ M 2□ F	29 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Jul. 9,	9ar) 9. Bin 1974	thplace (State or Foreignatry) MD
wow I		10a. State 10b. County	10	10c. City, Town or Lo					10d. Inside City Limit
Sa-f a	ecto	FL Semino	ie		Oviedo				1 ☐ Yes 2 🙀 N
3a or 2	Funeral Director	10e. Street and Number 121 Reserve Circ	le, Apt. 20	1	10f. Zip Code 3276	65	10g.	Citizen of What Co	-
ms 2	hera	11. Marital Status	12. Was Decedent E		Was Decedent of H	ispanic Origin? (Spe in, Mexican, Puerto	cify Yes or No-	14. Race - Ame	
yene. Ir than "natural", or Items 23a or 28a-f show The Medical Examiner must be notified at	þ	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Black, Whit	e, etc. White
natur	Completed	15. Decedent's (Specify only highest of	Education trade completed)	(Give	dent's Usual Occup	during most of worki	ng 16b	. Kind of Business/	Industry
then	ldmo	Elementary/Secondary (0-12)	College (1-4or 5-	+) ///e.	<i>DO NOT use retired</i> Electricia	")		K & W Ele	ctric
T to the		12 17. Father's Name (First, Middle, Lat	st)		JICCCI ICIC		(First, Middle, Maid		CCLIC
0 0	To Be	Robert B. Jewet					A. Ricklin	•	
7 is m Treum		19a. Informant's Name/Relationship Bonnie M. Kello				and Number or Rura			
reain litem 27 rother tr		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place		ate 200	Location - City or	Town, State
ortent: if injury or		1 ☐ Burial 2 ☑ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		Metro Cr		i Mal.	19, 104 Ba	altimore,	MD
Department of the properties o		21. Signature of Fundral Service Lic	ensee	Ĩ	Name and Address Barranco & 195 Gov. I	Sons, P. Ritchie Hv	A. Severi	na Park F na Park,	uneral Hom MD 21146
ysician Medical aminer		23a. Parf. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each lin	9 .	ic Intoxi		Toophalory arroot,		Approximate Interval Between Onset and Death
sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury that initiated events resulting in death) Last	c	consequence of):					
attending physicien and for use as the burial	cai	IF FEMALE:	d						
ed by the attend detached for us	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
sign d be	by	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.			the cause of death?
has ye 2	Completed						24a. Was an autopsy performed	prior to death?	topsy findings availab completion of cause o
certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
	2	1X Yes 2 No 27. Manner of Death	Hospital:			4 Nursing non			in) at scene
this ald dir	Certification:	1 □Natural 5 □ Pending 2 □ Accident investigati	3/14/04	Found	A M Work	/ O REPAIL	8d. Describe how in Inknown	njury occurred	
After this funeral dir	₹	3 ☐ Suicide 6 🖫 Could not 4 ☐ Homicide determine	building, etc.	ry - At home, farm, str (Specify)	eet, factory, office	2	8f. Location (Street City or Town, St	and Number or Rulate) 715 Sh	ore Rd.
itter upain. Sirector: After this in by the funeral dir	erti			esidence my knowledge, death	n occurred at the tim	e date and place a	nd due to the cause	v(s) and manner as	stated.
itter upain. Sirector: After this in by the funeral dir		29a. Certifier 1 Certifying F	'hysician: To the best of	examination and/or in	vestination in my an	inion death accurre	WALLING HITTH DATA 2	and place, and due	
itter upain. Sirector: After this in by the funeral dir	edical	one)	Physician: To the best of immer: On the basis of and manner stat	examination and/or in	vestigation, in my op	inion, death occurre			
After this		(Check only 24) Medical Ext	iminer: On the basis of a	examination and/or in	29c. License	ninion, death occurre number	29d. l	Date signed (Month	, Day, Year)

			1 - For State Registrar	State of M	aryla	nd / Depa	artme rtifica	nt of F	lealth and Death	d Mental	Hygier	- 4	4 10426
			1. Decedent's Name (First, Middle, Las	st)							of Death		3. Time of Death
	Physici /Media		Ethel Eleanor Ja	cobs						Man	rch !	9 200	2:35 P.M.
1	Examir		4a. Fecility Name (If not institution, give	street and number)			4b. Cit	y, Town, o	Location of De			c. County of D	eeth
			North Hrunde	1 Hospir	ta 1		61	en t	surni(0		Anne	Arundel
п	Funeral		5. Social Security Number 6. S	9x ' 17. Ag □ M 21X1 F	95 (In yrs	. last birthday) Yrs.	Month	s Days	If Under 24 H Hours Mi	in. (Mont	h, Day, Yea	9. l	Birthplece (State or Foreign Country)
	Director		220-01-5411 Usuel Residence of Decedent		95	113.				Jan	. 25,	1909	MD
	yland		10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	Mar se-f	tor	MD Anne A	rundel				Aı	rnold				1 □ Yes 2 🙀 No
	or 28	Director	10e. Street and Number				10f. Z	ip Code			10g. C	Citizen of What	Country?
	ath w	rai	1223 Farley Cou	rt					21012			USA	
	er de	Funerai I	11. Marital Status	12. Was Decedent Armed Forces?		J.S. 13.	Was Dec	edent of H	ispanic Origin? In, Mexican, Pu	(Specify Yes	or No-	14. Race - A Black, W	merican Indian,
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No			2 / 2 No	Specify:				White
Ö	72 hours after death with the Maryland heature!; or items 23s or 28s-f show dical Exemirer must be routiled at	ed	15. Decedent's Ed			16a. Dece	ient's Us	ual Occun	ation		16h	Kind of Busine	es/Industry
215	within 72 ene. than "na	Completed	(Specify only highest gra	de completed) College (1-4or 5		(Give	kind of v	vork done d use retired	during most of w	vorking	100.	rand or busine	samuustry
21	e filed within al Hygiene. I other than '	mo.	12	College (1-40)	,+,		H	iomema	aker				Home
p	be filed within 72 hours after death with the Marylan stal Hygiene. ed other than "natural", or items 23s or 28s-1 show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)						18. Mother's N	ame (First, M.	iddle, Maide	n Sumame)	
yla	2 should be and Mental is marked (sumatic ev	ို	William A. Clubb							ephine			
Maryland 21215-0036	ges 1 and 2 should it of Health and Men if Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (7						and Number or i			or Town, State	e, Zip Code)
e,	1 and 2 Health tem 27		Gerald J. Jacobs 20a. Method of Disposition	/ SON	20h	I ZZ3 Place of Dispo	4.46.		Court, A		_	21012	
Baltimore,	permit. Peges 1 and Department of Heall Important: If Item 2 any injury or other once.		1 ABurial 2 Cremation 3			cemetery, cren	natory or	other plac		Mar. 13	3	Location - City	
Ħ	iit. Pe intmer injury injury		* 4 □ Donation 5 □ Other (Specify 21. Signature of Fureral Service Licen		INE	w Cathe				2004	Ва	ltimore	e, MD
Ba	permit. Departr Importa		16.00	216		Pa	rran	CO &	Sons, P	A. Se	verna	Park F	uneral Home MD 21146
b			23a. Part1. Enter the disease, or comp	olications that caused	the dea	th. Do not ente	5 GO or the mo	V. Ri	tchie H	wy, Se	verna	Park,	MD 21146 Approximate
	Physician		Immediate Cause (Final	one cause on each lin	10.			,			,		Interval Between Onset and Death
6	/Medical		disease or condition resulting in death)	a. Due to (or is	> 17	quence of);	_			3,400			
B	Examiner			100	ibe	tos	m	alli	tus				
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consec	nuence of	7.1						
	acute ind trans	Examiner	that initiated events	c									
30,	cate be executed obysicien and the burial-transit	Ē	resulting in death) Last	Due to (or as	a consec	quence of):							
8760,	cate be executed physicien and s the burial-transit	dicai		d									(A)
9 xo	the death certific y the attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pream	2004			-				
Bo	atte for	cian	in the past 12 months?	1⊟Live birth 4⊟Pregnant at	2 Feta	al death 3 🗆	Ectopic p	regnancy			- 13	23d. Date of d Month	elivery Day Year
o.	that the de ed by the detached	ysle	1 U Yes 2 No 9 Unknown	9□ Unknown	tillio or c	10a[ii 3]	Ottiel (s	pecity)					
σ.	The law requires that ate has been signed boage 2 should be deta	by Pr	Part II. Other significant conditions co	ntributing to death be	ut not res	sulting in the un	derlying	cause give	n in Part I.	23e. (Did tobacco	use contribute	to the cause of death?
Records,	quires on signe	g pa								- -	Yes 2	No 3□1	Probably 4 DUnknown
ပ္သ	law requir as been si 2 should	Completed								24a. \	Masan	24b. Were a	autopsy findings available
	The lav	E								ļ p	utopsy erformed?	prior to death?	completion of cause of
Vital		BeC	25. Was case referred to medical						26. Place of De	1 ☐ Yo		0 1 □ Ye	s 2 No
	dis Y	ToE	examiner?	Hospital:	nt 2	ER/Outpatient	3 D	OA Othe	_			6 Other (Sp	ecify)
0	ng Ph fter th		27. Manner of Death 1 Natural 5 ☐ Pending	28a. te of Injur (Month, Day	y Ye <i>ar</i>)	28b. Time of Injury		28c. Injury Work				iry occurred	
sio	ttendi death. ctor: A / the fu	cati	Accident investigation 3 Suicide 6 Could not be				M	1 🗆 Y	es 2 □No				
Division of	for At after o Diraci	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	iry - At h	ome, farm, stre y)	et, factor	y, office		28f. Location City or	Town, State	nd Number or F e)	Rural Route Number,
	pitel ours a eral l	al Ce	29a. Certifier 1 Certifying Phy	relation. To the book									
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medica	(Check only 2 Medical Exami	sician: To the best of iner: On the basis of and manner sta	examina	tion and/or inv	occurred	at the time n, in my op	e, date and plac inion, death occ	e, and due to curred at the time	the cause(s me, date an	i) and manner a d place, and du	as stated. se to the cause(s)
	ro the	Me	29b. Signature and title of certifier				29	c. License	number		29d. Da	ate signed (Mor	nth, Day, Year)
)	, , , ,) And		MA	1.	15	112	977		EM.		3 2004
		-	30. Name and address of person who co	ompleted cause of de	ath (Iten	1 23a) (Type, F	Print) .	VTV	111		Her	run "	1 2007
_			mokn Okeringi.	30/ Hosper	m)	Deve,	66	m B	ume.	ms.	2006).	
	Sta		31. Pate filed (Month, Day, Year)	32. Pegistra	r's Signa	iture							
	Registra	37	MAR 1 2 7	JU4 July	100.00	AL AL	SUA!	A					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended Item#20B,03/15/04 Certificate of Death CH/WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** March 2:30 P M 2004 Alfred John Kelleher 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**№** M 2□F Yrs Director 144-12-0155 79 Sept.5, 1924 NJ Usuel Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Worcester Ocean Pines 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 86 Lookout Point 21811 US 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married Married 5 Specify: White 1 ☐ Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 al Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Insurance Broker Insurance Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental H Pages 1 and 2 should be William J. Kelleher Margaret M. Pio ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 86 Lookout Pt., Ocean Pines, Md. 21811 Constance A. Kelleher 150/50 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 03/13/04 20a Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Garden of the Pines 4-13-04 Ocean Pines, Md. *4 ☐ Donation 5 ☐ Other (Specify) 108 William St., 21. Signature of Freeral Service Licenses 22. Name and Address of Facility The Burbage Funeral Home Berlin, Md. 21811 23a. Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENERPROVASCULAR **Physician** 5 de disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 20 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 ☐ No 27. Mannel Ceath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death, 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide illed in within 24 hours a 1 🗲 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

C,H, 20+1

5510

State Registrar OLSAN CLTY (

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OLD

MAR 1 2 2004

31. Date filed (Month, Day, Year)

Registrar's Signature

			1 - For State Registrar	State of Maryland			of H	ealth a		ental Hygi	ene 2	004	1042
	Physici /Media		Decedent's Name (First, Middle, Last Mabel A.							2. Date of Death Month March	Day	Year 2004	3. Time of Death 0855 A
	Examir		4a. Facility Name (If not institution, give Calvert Manor He	street and number)	r	4b. City, T	own, or		f Death		4c. Count	y of Death	
	Funeral Director		5. Social Security Number 6. Se			If Under 1		If Under: Hours	Min.	8. Date of Birth (Month, Day, April 22,		9. Birthp	olace (State or Foreig ntry) nsylvania
death with the Maryland	I Health and Mental hygiene. Item 27 is marked other than "netural", or items 23a or 28e-f ahow other traumatic event, the Madical Examiner must be notified at	al Director	10a. State 10b. County Maryland Cecil 10e. Street and Number 50 Alda Drive		, Town or Lo	10f. Zip (Code .921			10	g. Citizen of Unite		•
le le	ral, or items Exeminer ma	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decede If Yes, speci 1 ☐ Yes 2			gin? (Spec , Puerto R	offy Yes or No- lican, etc.)			
within 72 hours after	iene. than "netu he Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual kind of work DO NOT use ⊇rk	done d	uring most	of workin	g 1	6b. Kind of E	Business/In	ŕ
Maryianu 2 12 13-0030 d 2 should be filed within 72 hours af	Mental Hygien arked other th atic event, the	To Be Co	17. Father's Name (First, Middle, Last) Joseph Strauss		<u> </u>	_T 1/			r's Name rl Sł	(First, Middle, M			1.55
es 1 an	nt of Health and N I: If item 27 is ma r or other trauma		19a. Informant's Nama/Relationship (7) Ethel Strauss/Sis 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ (1)	ter-in-law 20b. Pla Compared from State	50 A. ace of Dispo	lda Dr sition (Naminatory or oth	ive e of her place	, Elk	ton, Da larch	17, P	d 2192 Oc. Location hilade	21 - City or To elphia	own, State
permit. Pages 1 ar	Department of Importent: If is any injury or		*4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens		thwood Hi	Name and	Address OME	s of Facility	004 Funer Stre	als, P.	ennsyl A. ton, N		and 21921
E)	ysician Medical kaminer	ner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only olimmediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying	a. Provided Due to (or as a consequence) Due to (or as a consequence)	Cas ence of): Well	pivole	of dying	, such as	cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
ificate be executed	g physician and as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. P/T Due to (or as a conseque	ence of):								
The law requires that the death certifica	ed by the attending phy detached for use as th	by Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnan 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3□	Ectopic pre Other (spe						ate of delive onth	ory Day Year
requires that	been signed t should be det		Part II. Other significant conditions co	entributing to death but not resul	lting in fhe u	nderlying ca	use give	n in Part I.			cco use con		ne cause of death?
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Sicis	s cert	To B	examiner?	Hospital: 1 ☐ Inpatienf 2 ☐ 5	R/Outpatier	at 3□ DO#	Othe			e 5 Resider		her (Specif	
lor Attending Physician:	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Dafe of Injury (Month, Day Year)	28b. Time of Injury	28 M	c. Injury Work 1 Y	at ? ′es 2 □ t	No 28	8d. Describe how 8f. Location (Stre	v injury occur	rred	
To the Hospitel or	within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phy	building, etc. (Specify) /sician: To the best of my know iner: On the basis of examination) 	n occurred a	t the tim	e, date and	d place, ar	City or Town,	State)	anner as st	ated.
To the F	within 2- To the f complete	Medical	29b. Signature and title of certifier ### CLIN U.S.	and manner stated.		29c.	License	number			d. Date signe		
	5		30. Name and address of person who of Jui-Chih Hsu, M.E.	ompleted cause of death (Item	in St		Elk	ton,	Mary]	land 219	21		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure								

			For	State of Maryland / Dep		•	iene
			1 - State Registrar		ertificate of Death		og. No. 2004 10429
	6	. 1	1. Decedent's Name (First, Middle, Last))		2. Date of Dear Month	
	Physici /Medio		Tofi1	Theodore Kam	inski	March	13, 2004 1:25P M
10	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death
			9605 Michael Dri	ive	Clinton		Prince George's
~#	Funeral		Social Security Number 6. Security Number) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birtholace (State or Foreign
	Director		430-24-2071	Xm 2□ F 82 Yrs.	Months Days Hours Will	April 2	
	D S		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L			
	sho	5	Maryland Prince G	eorge's Clin			10d. Inside City Limits 1 ☐ Yes 2 ☐ Yo
	Se-f	Director		CIIII			**
	Mith t	ä	10e. Street and Number 9605 Michael	Drive	10f. Zip Code	1	0g. Citizen of What Country?
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23s or 28s-f show ent, It a Medical Exacts as must be notified at	Funerai			20735		U.S.A.
	er de Item	nu	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs aft	by F	3 □ Widowed 4 □ Divorced	1	1 ☐ Yes 2 🔀 No Specify:		Specify: White
9	hou	edi	15. Decedent's Edu		edent's Usual Occupation		16b. Kind of Business/Industry
5	in 72	plet	(Specify only highest grade	e completed) (Give	e kind of work done during most of wo DO NOT use retired)	rking	Tob. Nind of Educates symbols by
2	iene iene	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	tore Manager		Retail Food Store
ğ	Hyg othe	BeC	17. Father's Name (First, Middle, Last)			me (First, Middle, A	Aaiden Sumame)
a	ked be	ToB	Stanley T.	Kaminski	Mary	Krolcy	zk
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-1 show atmatic event, it a Medical Exact marking the notified at	-	19a. Informant's Name/Relationship (Ty	rpe, Print) 19b. Mail	ing Address (Street and Number or Ri	ural Route Number,	City or Town, State, Zip Code)
	s 1 and 2 should t Health and Men item 27 is marke other traumatic		Stanley Kaminsk		05 Michael Drive		
Baltimore,	of Health of Health litem 27 i		20a. Mathod of Disposition	20b. Place of Dispo		hDate 2	20c. Location - City or Town, State
Ë	permit. Pages Department of I important: If its any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State Maryland	Veterans Cemeter	y 2004	heltenhamMaryland
Ē	permit. I Departm Importal any inju		21. Signature of Funeral Service License	ee 2	2. Name and Address of Facility	2004	
ñ	permit. Depart Import any inj		Kolli R. Ha				Road Clinton, MD20735
			23a. Pert1. Enter the disease, or compli	ications that caused the death. Do not en			est, Approximate
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6	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	000000		OWDIA
T.	Examiner			J			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
	te be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events	•			
o,	an ar rial-tı		resulting in death) Last	Due to (or as a consequence of):			
760,	9 4 9	cai		1			
99	death certificat e attending phy id for use as the	Physician/Medi	15.55.441.5				
Box	th ce endi	ar.	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 [Ectopic pregnancy		23d. Date of delivery
	0 00	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		Other (specify)		Month Day Year
o.	law requires that the de as been signed by the a 2 should be detached t	h	9 🗆 Unknown				
- Ś	es th igned be de	by	Part II. Other significant conditions con	ntributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
D.C	w requir been si should	ted				1 XYe	s 2 No 3 Probably 4 Unknown
Vital Records,	as be	Completed				24a. Was an autopsy	
Ĭ	The lay cate has page 2	NO.				perform	
Ita	ysician: Th is certificate director, paç	Bec	25. Was case referred to medical		26. Place of Dea	th (Check only one	
	d is	To	examiner?	lospital: 1 Inpatient 2 ER/Outpatier	nt 3 DOA Other: 4 Nursing H	ome 5 Resider	nce 6 Other (Specify)
0	ding Pt th. After the funeral		27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time o	f 28c. Injury at Work?	28d. Describe how	w injury occurred
000	uttendii death. ctor: A y the fu	atic	2 ☐ Accident investigation		M 1 Yes 2 No		
Division of	4 - 6 0	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)
	iteio irsaf raiDi ledir	S.					
	e Hospitei or 124 hours afte le Funeral Dire letely filled in t	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	sician: To the best of my knowledge, death	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the car	use(s) and manner as stated.
	To the Hos within 24 ho To the Func completely f	Med		and manner stated.			
	S in S	<	29b. Signature and title of certifler	1/1/	N 17 N Z	_ 29	d. Date signed (Month, Day, Year)
0			1 W Wall	15U	D-11005		DIVOY
1	B 781			mpleted cause of death (Item 23a) (Type,		1 11	
U	انهل		David J. Haidak,	M.D. 32. Redistrar's Signature	8926 Woodyard F	(d #201 C	linton, MD 20735
I	Sta Registr	-		004 Mague #	Coarles		

		•	For State Registrar			State of	f Maryl			artment <i>tificate</i>				lental Hy	giene Reg. No	200	4	104	30
	4	4	1. Decedent's Name	e (First, Middle	, Last)									2. Date of De Month	aath Da	y Ye	ar	3. Time of D)eath
	Physicia /Medic		Robert			Mel	vin			Kehm	ı,II	I		03	13			0557) M
	Examin		4a. Facility Name (I	f not institution	, give st	reet and nur	nber)			4b. City, T	own, or	Location	of Death		4c	. County of D			
			PENINSULA		9/ 1			ter				46/56				Mic	om.	100	
	Funeral		Social Security N		6. Sex	M 2□F	7. Age (In	yrs. last birt		If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di	rth ay, Year)	9.	Birthpl	ace (State or try)	Foreign
v ,	Director		219-28-09		7	M 2UF	72		Yrs.					11-17-			lary	land	
. ^	pu *		Usual Residence of 10a. State	10b. County		-	10c	City, Town	orlo	cation							10	0d. Inside City	/ Limits
267	anyla eho	5																1X Yes	
05	the M	Director	MD 10e, Street and Nur	Some	rset			Deal	I	sland 10f. Zip C	`ode				10a Cit	izen of What	Coun	Y	
1	with a or	ᡖ	23165 R		200										log. Oil			uy.	
18 20	death with the Maryland me 23a or 28a-f ehow rmus Le noillied at	Funeral	11. Marital Status	OTIE D		2. Was Dece	adent Ever	in II S	13 \		182		igin? (Sp	acity Yes or Ni	2-	USA 14. Race - A		an Indian.	
1	or Item	Š	1 Never Marri	ed 2 Marr		Armed Fo	rces?		I	f Yes, specif	y Cubar	n, Mexicar	, Puerto	ecify Yes or No Rican, etc.)		Black, V			
<i>21</i>	irs af	by	3 Widowed	. ,		1 Yes If Yes, Giv Year or D	^{re} ates: Koi	rean	1	I□Yes 2	No	Specify:				Specify:	Whi	+0	
219 5-0036	72 hours natural',	ed		15. Decedent	t's Educa	ation		16a.	Deced	ient's Usual	Occupa	ation			16b. K	ind of Busine			
215	within 7. ene. than "n	ple	(Speci Elementary/Seco	ndary (0-12)	st grade	College (1	-4or 5+)	_	life. L	kind of work OO NOT use	aone a retired,	luring mos)	I OF WORK	ing					
7 × 5	d with	Completed	10			none			arı	enter					Co	nstruc	tic	n	
bent and 2	e file at Hy I othe vent,	Be	17. Father's Name	(First, Middle,	Last)							18. Mothe	er's Nam	e (First, Middle	, Maiden	Sumame)			
o b	Venti Menti Prkad	2	Robert	Melvin	Keh	m, II						Mild	lred	Myers					
, Robert Maryland 21	2 sho and ie mu		19a. Informant's Na	ame/Relations	hip (Typ	e, Print)		19b.	Mailin	g Address (Street a	and Numbe	er or Rur	al Route Numb	er, City o	or Town, Stat	e, Zip	Code)	
	and ealth n 27 uar tr		Dorothy	S. Keh	n/Wi	fe		23	165	Rolf	e La	ane,		Island					
ehm more,	of Ho		20a. Method of Disp		3 □ Be	moval from	State 20	b. Place of cemeter	Dispo: y, cren	sition (Name natory or oth	of erplace	ө)		Date	20c. Lo	ocation - City	or To	wn, State	
Kehmaltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie markad other than "natural", or Iteme 23a or 28a-f show any injury or othar traumatic event, the Medical Examine must be notified at once.		1 □ Burial 2 `4 □ Donation	5 ☐ Other (S	pecify)		5	Salist	ury	7 Crem	ato	ry	03/1	5/2004	Sal:	isbury	, M	arylan	.d
	permit. DepartnImports eny inju		21 Signature of Fu	negal Service	License				H1	Name and nman	Addres Fune	s of Facili	y Home						
ω_	80589	\preceq	mus o	Syll	NA	W		1295	\perp 11	673 S	omei	rset	Ave.	. Princ	ess	Anne,	MD	21853	
			3a. Part1. Enter the shock, or hea	he disease, or rt failure. List	complication only one	ations that c cause on e	aused the dach line.	death. Dor	ot ente	er the mode	of dying	g, such as	cardiac	or respiratory a	rrest,			Approximate Interval Between	een
	Physician		Immediate Cause disease or condition	(Final on	a	Mé	tart	alie	. 1	Lun	3	Ca	Wes	200				Onset and De	h
	/Medical Examiner		resulting in death)			Due to	(or as a cor	sequence	of):		0						-		
	200	_	Sequentially list co	nditions,	b.		,										_		
	e sit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nmediate ortying	l	Due to (or as a cor	isequence o	of):										
	and I-tran	хап	that initiated events resulting in death)	Last	c.	Due to 6	or as a con	sequence o	of).									·	
760,	ate be executed nysician and he burial-transit	calE					(0. 00 0 00.		,.										
	phys the				d.												-		
. Box 68	Physician: The law requires that the death certifica this certificate has been signed by the attending ph ral director, page 2 should be detached for use as th	by Physiclan/Med	IF FEMALE:		23	c. If yes, out	come of pre	egnancy								23d. Date of	delive	n/	
Bo	atten for u	clan	23b. Was deceden in the past 12	months?		1 ☐Live b		Fetal death		Ectopic pred						Month Month		Day Ye	ar
Ö	the d	ıysi	1 ☐ Yes 2 ☐ 9 ☐ Unknown			9□ Unkno			_										
P.O.	that led b deta	F	Part II. Other signif	ficent condition	ns cont	ributing to de	eath but not	t resulting in	the ur	nderlying cau	ıse give	n in Part I		23e. Did	tobacco i	use contribut	e to the	e cause of dea	ath?
Division of Vital Records,	uires sigr	D D												1 🗆	Yes 2	□ No 3 🙀	Proba	ably 4 Dun	known
Ö	w req	Completed												24a. Was	an	24b. Were	autop	osy findings av	vailable
Re	The la cate has page 2	mc													crmed?	prior death	to com	npletion of cau	
la	in: T		25. Was case refer	red to medical					_			26 Place	of Deat	1 ☐ Yes	2 No	10,	res	2□ No	
5	scert	To Be	examiner?	/	_	ospital:	Inpatient	2 ER/Out	tpatien	t 3 DOA	Othe	۸۲۰		me 5 Res		6 □Other /9	Snacify	0	
of	y Phy er this	<u>۱</u> : ⊔	27. Manper of Deat				of Injury th, Day Yea		ime of		c. Injury Work			28d. Describe			роспу	/	
<u>o</u>	nding ith. :: Afte	atlo	 IZNatural Accident 	5 🗌 Pendin investig		(Mon	m, Day rea	(r) Ir	njury	м		/es 2 🗌	No						
<u>S</u>	Attending ir death. ector: After by the fune	ific	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be iined	28e. Place	of Injury - a	At home, fai	rm, str	eet, factory,	office			28f. Location (City or To	Street an	d Number of	Rural	Route Numbe	er,
Ö	safte safte al Dir	Certification:	4 🗀 Homead			Danai	11g, 6tc. (O)	occuy)						Only on 10	mi, State	'/			
	ospit hour uners ly fille		29a. Certifier (Check only	1 Certifyin	g Physi	cien: To the	best of my	knowledge	, death	occurred at	t the tim	e, date ar	d place,	and due to the	cause(s)	and manner	r as sta	ated.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	one)			and man	ner stated.	- A	201 IIIV				un occur	eu at the time,					
	To the within 2 To the complet	Σ	29b. Signature and	title of certifie	1	olen	X I	-Cl	who	29c.	License	number	e (== -		29d. Dat	te signed (M	onth, [Day, Year)	
			ROB	ERT	L.	CLIN	MOR	, MY	2	1	00	56	174	2	3	1131	04		
			30. Name and addr	ress of person	who con	npleted caus	e of death	(Item 23a) (Туре,	Print)	^ .	, ^	4.0		3 - 1				
_			145. E	· ()	4)861	LOLL	51	51	42	15 1541	RI	/ /	3/)	218	201				
55 A	Sta		31. Date filed (Mon	nth, Day, Year)) 1 "	32. R	legistrar's S	ignature	1.	1									
	Registr	ar 🐰		יואויו	1 1	2004	CIN	we	4	A COM	w								

		 Decedent's Name (First, 	Middle, Li	ast)								2. Date of I	Death			3. Time of De
hysic /Medi		Michael Hu	ll K	elly								Month March	_	ay 16	Year 2004	11:50
Exami		4a. Facility Name (If not inst	itution, gi	ive street and	d number)			4b. City,	Town, or	Location	of Death		4	c. County	y of Death	
		4866 Montgom				4				tt Ci				Hov	ward	
ineral rector		5. Social Security Number 227-64-5057 Usual Residence of Decede		Sex 1 ∑ M 2□	F	(In yrs.) 54	last birthday) Yrs.	Months	r 1 Year Days	If Under Hours	Min.	B. Date of I (Month, I	Day, Year		1	olace (State or F ntry) OH
a-f show	tor	10a. State 10b. C		rd		10c. City	y, Town or Lo	icott	City	Y						10d. Inside City
be not	Funeral Director	10e. Street and Number		. 7004	•			10f. Zip	Code	1042			10g. C	itizen of	What Cou	*
18 23.	erai	4866 Montgo	mery		Decedent E	ver in U	S 13	Was Dece		1043	igin? (Sp	acify Yes or I	No.	14 Rac	USA	can Indian,
ral', or itam Examiner	b	1 Never Married 2 3 Widowed 4 X Div		1 DY	ed Forces? Yes 2 XNo s, Give or Dates:			If Yes, spe		Specify:		ecify Yes or I Rican, etc.)	10-		ck, White,	
r then "neturel", or items 23e or 28e-f show the Medical Examiner must be notified at	Completed	15. Dec (Specify only) Elementary/Secondary (0	highest gi		ge (1-4or 5+	-)		dent's Usu kind of wo DO NOT u ounty	ork done d ise retired	furing mos)					usiness/in	dustry ernment
event.	To Be Co	17. Father's Name (First, Mi Robert Kel	_	st)	4		<u> </u>			18. Mothe	er's Nam	e (First, Midd	lle, Maide			
. 3		19a. Informant's Name/Rela	ationship	(Type, Print))		19b. Maili	ng Address	s (Street a	and Numbe	er or Run	ai Route Num	ber, City	or Town,	, State, Zip	Code)
tem 27 other tra		Erin Marie K	elly	/Daugh	nter	Jan. 5	-	-		rive		, Glen	-			21060
Important: If item any injury or othe once.		20a. Method of Disposition 1 Burial 2 XCrema 1 Donation 5 Ott			from State	a	Place of Dispo emetery, crea Metro (matory or o Crema	tory		3/19		Ва	ltim	ore,	MD
any in		21. Signature of Funeral Se	rvice Lice	ensee	11		\mathbf{B}^{2}	2. Name ar arran	nd Addres	s of Facility Sons	P.	A. Sev	erna	Par	k Fur	neral Ho 21146
3400	Titler	1110111		1 1 V			143	95 GO	V. R	LUCIIL	e nw	y, sev	erna	ral	L' CATT	7 41140
sician edical niner	ilner	23a. Pall1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	. List only	a. Com	on each line	consequ	of Chroruence of):	ter the mod	de of dying	g, such as				. Far	K, M.	Approximate Interval Betwee Onset and Dea
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State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dorothy C. Kirby March 13, 2004 2:38 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Jun. 5, 1935 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Washington, DC 68 578-48-8361 Director Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits or 28e-f show event, the Medical Examiner must be notified at MD Anne Arundel Arnold 1 Tyes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 608 Oakland Hills Drive 21012 USA or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify. þ 3 X Widowed 4 ☐ Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Jewelry Salesperson Retail of Health and Mental Hygic Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Colliflower Dorothy Mae Kelley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Kirby/Son 1398 Broadneck Court, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of I-Importent: If Ite any injury or ot once. Mar. 17, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signature of Puneral Service-License Parranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Pant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Myocordia 24 hours /Medical Examiner Dilmonory obstructive noniz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Accerbation Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 physician Physician/Medical the t IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 | Fetal death in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 🗌 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: မ 1 Tes 2 No 1 atient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director; 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel D The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 3-12-04 1)0060176 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Annole Medical Genter A type mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 5 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 10433 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2004 Month **Physician** HUBERT WINFRED LAFLEUR, JR. March 12, 1610 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Center Clinton Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | December 3, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) 1931 New York 7. Age (In yrs. last birthday) **Funeral)**(□ M 2 □ F December 72 031-30-1110 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Charles Maryland Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā 4614 Harwich Drive 20601 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🗶☐ No Specify: Š 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1953-73 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 **USAF** Tec Sargeant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hubert Winfred LaFleur Helena Mabel LaValley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I tother tra Marion E. LaFleur - Wife 4614 Harwich Drive, Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Trinity Memorial Gdns 3-17-04 A □ Donation 5 □ Other (Specify) Waldorf, MD 21. Signature of Funeral Service Licensee M00053 Huntt Funeral Home P. 0. box 156, Waldorf, MD 20604 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIOPYLMONARY ARREST /Medical Due to (or as a consequence of): Examiner CUROMARY ARTERY DISEASE Sequentially list conditions, if any, leading to influediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): HY PERTENSION. resulting in death) Last Due to (or as a consequence of): O. Box 68760 Physician/Medical DIATIETES anding I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s autopsy performed' 1 ☐ Yes 2 DNo director, 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 XYes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANIL IC: NAMADAN: SOUTHERN MARYLAND HOSPITAL CENTER

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31. Date filed (Month,

State of Maryland / Department of Health and Mental Hygiene 2004 10434 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2004 Linda Lewis March 10, 9:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Prince Georges Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2X1F Director Yrs. 215-70-7620 47 February 6,1957 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at Maryland Prince Georges Upper Marlboro 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11604 Molley Berry Road 20772 238 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 ō, 1 ☐ Yes 2 X No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) D.C. Government Public Affairs Specialist 12 other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event spice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Fielder Lewis Sr. Annie Rebecca Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald Johnson/Brother 11604 Molley Berry Rd Upper Marlboro, Maryland 20772 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Upper Marlboro, Nottingnam Myers
UMC Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 3/17/04 Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Desca Offer MO1323 Adams Funeral Home P.A. Aquasco, Maryland 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee Onset and De Immediate Cause (Final disease or condition resulting in death) and Death **Physician** an Know /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of): The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760 by Physiclan/Medical attending | IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Durknown should should Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an 2 No certificate 1□ Yes 2□ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death 2 ☐ Accident Director 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Directomoletely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50454 March, 10, 30. Name and address of Jerson who completed cause of death (Item 23a) (Type, Print) FRASTOO AZDANI Silver speins mp 20902 9801 Credique Ave 3-41 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) MAR 1 5 State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar AMEND #20a-c PER FH CCHD 3/15/04 DB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 13,2004 **Physician** Ellen. Lucille Lewis 5:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bradford Oaks Nursing Home Clinton Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** 1 M 2∏F 579 07 5019 93 Director June 6. 1910 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at Maryland Anne Arundel Deale 1 Yes 2 100 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or filed within 72 hours after death with 612 Clark Ave 20751 United States Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 3 ☐ No Specify: Specify: White 3XXWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) nit. Pages 1 and 2 should be filed withi artment of Health and Mental Hygiene. orlent: If item 27 is marked other than injury or othar traumatic event, Italy. Sales Clerk 7th Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Knapp Ellen Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alvin Knapp (Brother) 612 Clark Ave, Deale , Maryland 20751 20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillerest Memorial March 27,2004 20a. Method of Disposition 20c. Location - City or Town, State CLINTON, MARYLAND Annapolis, Maryland 1 23 Burial 2XX Cremation 3 Removal from State permit. Page Department of Importent: If eny injury or * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Fundal once. MOUI Alexandria Ferry Road, Clinton, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 attending physician Physician/Medicai the IF FFMALE use a 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed7 Yes 212 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: ↑ ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending М 1 Yes 2 No death. investigation 2 Accident Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after within 24 hours at To the Funeral D Hospital Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certification 29c License number 29d. Date signed (Month, Day, Year) 30, Name and address of pythin who completed cause of death (Item 23a) (Type, Print) 03 TT. Washington MD 31. Date filed (Month, Qay, State MAR 15 2004 Registrar

	Hegistrar O	partment of Health and Meartificate of Death	Reg. No.
Physician /Medical	Decedent's Name (First, Middle, Last) Emma Irene Layton		2. Date of Death Month Day Year March 12, 2004 1:15 A M
Examiner	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Funeral	5729 Linkwood Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdi	East New Market	Dorchester 8. Date of Birth 9. Birthplace (State or Foreign
Director	214-66-8987 1 M 2 MF 82 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Dey, Yeer) 9. Birthplace (Stete or Foreign Country) June 10,1921 Maryland
ms 23a or 28a-f show rmust be notified at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
"natural", or Items 23e or 28e-f show solical Examiner must be notified at solice Examiner must be notified at letted by Funeral Director	Maryland Dorchester East M	ew Market	1 ☐ Yes 2 🕅 No
a not	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
23a ust b	5729 Linkwood Road	21631	USA
r items 23a or 28a-f s Ther must be notified Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
Dy F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 🖾 No Specify:	Specify: White
ted	15. Decedent's Education 16a. De	edent's Usual Occupation	16h Kind of Business/Industry
vent, the Medical Se Completed	(Specify only highest grade completed) (G. Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of workin DO NOT use retired)	g
Co		Homemaker	Own Home
Be Be	17. Father's Name (First, Middle, Last) James Monroe Cheesman	Mary Sell	(First, Middle, Maiden Sumame)
To			Route Number, City or Town, State, Zip Code)
rtra	Kimberlee Bisker/Granddaughter 572	_	
othe	20a. Method of Disposition 20b. Place of Dis	position (Name of Damatory or other place)	ate 20c. Location - City or Town, State
ury or	1 Labouriai 2 Cramation 3 Chamovariion State	Cemetery 3/15/2	2004 Eldorado, Maryland
any injury or other traumatic event, the Musi once. To Be Comple	21. Signature Funeral Service Tourness	22. Name and Address of Facility Celler Funeral Home, 06 Main Street, Eas	P. O. Box 207 st New Market, MD 21631
s the burial-transit us the burial-transit edical Examiner	23a. Fant: Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of it. Due to (or as a consequence of it.) Due to (or as a consequence of it.)	hter the mode of dying, such as cardiac or	Interval Between
leted by Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
d by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 170 3 Probably 4 Unknown
Completed			24a. Was an 24b. Were autopsy findings available
page 2			autopsy prior to completion of cause of death? 1 □ Yes 2 □ No
Be C	25. Was case referred to medical examiner?	26. Place of Death	
funeral director, pag Ilon; To Be Col	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	ent 3 DOA Other: 4 Nursing Hom	e 5 Desidence 6 Other (Specify)
atlon;	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at 28	Bd. Describe how injury occurred
ed in by the funeral	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	Bf. Location (Street and Number or Rural Route Number, City or Town, State)
completely filled in by the Medical Certifical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medicel Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, an nvestigation, in my opinion, death occurred	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
completely filled in by the fu	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	I agansu ou	#0059973	3/15/04
	30. Name/and/address of person who completed cause of death (Item 23a) (Typ The Bran bile St, Cam b	p. Print) Dridge MD 2	76/3,Patricia Johnson,MD
State Registrar	31. Date filed (Month, Day, WAR 1 7 2004	Societ &	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 4 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 03 15:40 **Physician** McCLENDON 05 AULETTE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Edward Ristiald UCCready Hosp. Hal 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 M 208 F 213-44-0908 Yrs. 09-07-46 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiens in Items are used in with the maryla important: if Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Xes 2 No Funeral Director COMERSET 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21817 U.S. F 614 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 2 → No Specify. Specify: Hack Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Handy's 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MyrHe tharles ant ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) daywher risfield, Cove Ad MD endon 150 Domeis 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MAYLMSCO 4 ☐ Donation 5 ☐ Other (Specify) COENELER U.M.C. Comoters 21. Signature of Funeral Service Licensee Name and Address of Facility Thong E. Ward Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21853 Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical NON SMALL CELL LUNG CANGER METASTATIC **Examiner** Physician/Medical Examiner or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last 23b. Did tobscco use contribute to the cause of death? After this certificete has been signed by the a funeral director, page 2 should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2□ No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of desth? 24a. Wes an autopsy performed? 2 XN0 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Nopatient 2 ER/Outpatient 3 DOA Medical Certification: To Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? within 24 hours efter death. To the Funerel Director: After completely filled in by the funer 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination snd/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

D 48098

04

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 1 1 2004

Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD

32. Regigrar's Signature

DHMH 16 Rev 6/95

Amend 03/15/	I:	Item, # 10e State of Maryland / Department of Health and Me 11- State of Maryland / Department of Health and Me 11- State of Maryland / Department of Health and Me 11- State of Maryland / Department of Death	ntal Hygi	•	
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) Tohn: 9. MARVEL	2. Date of Death Month Manch		+ 6 -0 5 FM
Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	Date of Birth (Month, Day,	Howar	
the Maryland 28a-f show Millind at		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10	g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
frems 236	a di cia	11. Marital Status		USA 14. Race - Arr Black, Wh Specify:	erican Indian,
Ind 21215-003 be filed within 72 hours tal Hygiene. Id other than "natural", event, tre Medical Exp. Be Completed by		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 College (1-4or 5+) Administrator	1	6b. Kind of Busines:	
Taryland 212: 2 should be filed within and Mental Hyglene. Is marked other than surmatic event, ILA.M. To Be Comp		17. Father's Name (First, Middle, Last) Henry J. Marvel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural F	dford		Zip Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or othar traumatic event. If a Medical Ever and once. To Be Completed by F	-	Barbara J. Marvel (wife) 20a. Method of Disposition 1 Burial 2 **Cremation 3 Bemoval from State 4 Donation 5 Other (Specify) 21. Signature of Fineral Service Liceusee 22. Name and Address of Facility McCre	11,2004		gton, DE
be executed be executed cician and be executed be executed cician and be executed cician and cician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respond to the state of t		st,	Approximate Interval Between Onset and Death TEN DAYS.
P.O. BOX 68 hat the death certificat d by the attending phy letached for use as the) and an an an an an an an an an an an an an	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 9		23d. Date of de Month	' Nivery Day Year
	2	CORONARY ARTERY DISPASE HYPERTENDION	1 ☐ Yes 24a. Was an autopsy performe	2 No 3 P	o the cause of death? robably 4 Unknown utopsy findings available completion of cause of
VISION Of VITAI Attending Physician: ar death. actor: Atter this certifica by the funeral director, f	3	25. Was case referred to medical examiner? 1 Yes 2 No	Check on one 5 Resident 1. Describe how	ce 6 Other (Sperinipury occurred	ecify)
_ தேவித்த 🔾	200	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and control of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date	e and place, and du	e to the cause(s)
O+IVA		29b. Signature and title of certifier D. 30 469 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.B. VELLANK, MD. 9055 CHEVROLET DRIVE: # 100. EL	M	d. Date signed (Monitorial Careh G	th. Day, Year) - 2004 MD 21042
State Registrar		e 31. Date filed (Month, Day, Year) 32. Registrar's Signature	,,		

			1 - For State Registrar	State of I	Maryland /	Depa Cer	artment of F tificate of	lealth an <i>Death</i>	d Mental H	lygien Reg. No		04	10439
Ö	Physici /Medic		1. Decedent's Name (First, Middle, Las JoAnn Ford Melic						2. Date of Month	Da	y Y	'ear	3. Time of Death 7:30 A ^M
	Examir Funeral		4a. Facility Name (If not institution, give 3300 Ken Allen Cot 5. Social Security Number 6. S	ırt	er) Age (In yrs. last	birthday)	4b. City, Town, of Glenwood If Under 1 Year	If Under 24		Н	oward		
e .	Director		214-42-1788 Usual Residence of Decedent	□M 2X1F	61	Yrs.	Months Days	Hours N	Jan.				ace (State or Foreign ry) land
	e Marylan la-f ehow	ctor	10a. State 10b. County Maryland Howard		10c. City, To		cation					10	0d. Inside City Limits 1 ☐ Yes 2 No
	uth with the	Funeral Directo	10e. Street and Number 3300 Ken Allen Cou	ırt			10f. Zip Code 21738			10g. Ci USA	tizen of Wh	at Count	ry?
5-0036	172 hours after death with the Maryland "natural", or Itams 23e or 28e-f ehow calcal Exteniner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date:	s? X No	į	Vas Decedent of H Yes, specify Cuba	lispanic Origin? an, Mexican, Pi Specify:	(Specify Yes or I uerto Rican, etc.)	No-	Specify:	America White, e	tc.
121	within ane. then	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0·12)	ucation de completed) College (1-4c	or 5+)	life. L	lent's Usual Occup kind of work done OO NOT use retired	ation during most of d)	working		ind of Busin	ness/Indi	ustry
ממ	ntal Hygi ed other	To Be Co	17. Father's Name (First, Middle, Last) Harry Paul Ford	1	50	ecret	ary	18. Mother's	Name (First, Midd		ineer: Sumame)	ing	Firm
	d 2 shi th and th and traum		19a. Informant's Name/Relationship (7						Rural Route Num				
altimore,	permil. Peges 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from Sta	20b. Place ceme	of Dispos stery, crem	sition (Name of latory or other place	Ma	archie 9, 2004	20c. L	ocation - Cit	ty or Tow	
Ban	permil. Depart Import any in		21. Signature of Funeral Service Licen	Little	MO1251	Go Be	ing Home verly L.	Heckro	ion Serv	. C1a	P.O. arksvi	ille.	MD 21029
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	i line.	rior	the mode of dyin			arrest,			Approximate Interval Between Onset and Death
,	executed in and ial-transit	I Examiner	Sequentially list conditions, I ary, Isaams to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence								
. DOX	death certii e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown		2 Fetal dea at time of death		Ectopic pregnancy Other (specify)				23d. Date o Month	,	/ Vear
ecords, P	The faw requires that the site has been signed by the page 2 should be detached.	ρ	Part II. Other significant conditions co	ntributing to death	but not resulting	g in the un	derlying cause give	en in Part I.					cause of death?
ital Reco	: The faw re cete has bev , page 2 sho	Completed							24a. Wa auto pen 1 🗆 Yes	opsy formed?	prior	r to comp	sy findings available pletion of cause of
VISION OF VIE	To the Hospital or Attending Physician: The inwithin 24 Hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	ation; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 Inpa 28a. Date of In (Month, D	iury 28b	Outpatient Time of Injury	28c. Injury Work	er: 4 ☐ Nursing	Death (Check only) Jean State of the second	sidence (Specify)	
SIA	ital or Atterns after destal Directoried in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	289. Place of I	njury - At home, etc. <i>(Specify)</i>	farm, stre	et, factory, office		28f. Location City or To	(Street an own, State	d Number o	or Rural F	Route Number,
	ne Hosp in 24 hou he Funei pletely fili	edicai	29a. Certifier 1 XX ertifying Phyone 2 Medical Exemples 2	rsician: To the besiner: On the basis and manner:	of examination a	ge, death and/or inve	occurred at the timestigation, in my op	e, date and pla sinion, death oc	ace, and due to the courred at the time	cause(s) , date and	and manne place, and	r as stat due to th	ed. ne cause(s)
,	To t Comp	×	29b. Signature and title of certifier	? al	len		29c. License	number 972			e signed (M		
(0)	Sta	te	30. Name and address of person who control of the second s	2411 W. F			,	206 Bal	timore, N	Maryl	and 2	1215	
	Registra	-	MAR 1 0 2	004	en be	A	make o						

	1 - For State of Maryland / Dep	partment of Health and Mental Hygertificate of Death	giene 2004 1044
Dhusista	Decedent's Name (First, Middle, Last)	2. Date of Dea	th 3. Time of Death
Physiciar /Medica		Month March	9 2004 6:43 A ^M
Examine		4b. City, Town, or Location of Death	4c. County of Deeth
	Heart Homes Assisted Living	Annapolis	Anne Arundel
Funeral Director	5. Social Security Number 336-01-3819 G. Sex 1 M 2 F 7. Age (In yrs. last birthday, 94 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug. 15	y, Year) 9. Birthplace (State or Foreign Country) Germany
land ow	10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
Many	Maryland Anne Arundel Annapolis		1 ☐ Yes 2 ☒ No
with the Ma a or 28a-f s	10e. Street and Number	10f. Zip Code	log. Citizen of What Country?
th wit	3134 Port Way	21403	United States
ifter death virilems 23a	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
urs afte	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No If Yes, Give 9 dear or Dates:	1 ☐ Yes 2 🛣 No Specify:	Specify: White
hour turel	3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Dece		
be filed within 72 hours after death with the Maryland tal Hygiene. at Hygiene and the standard of other than "naturel", or Items 23a or 28a-f show event, the Madreal Examiner man be notified at Re Commission by Eumarai Director	(Specify only highest grade completed) (Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
d 2 should be fitted within 72 hours alf the and Mental Hygienes 17 is marked other than "naturel; or traumatic event, the Miscient Exami To Re Commissed by E	Elementary/Secondary (0-12) College (1-4or 5+) Import		Gurniture
tal Hygie d other event, the	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, M	
should be nd Mental marked Imatic ev	Richard Otto Andreas Muller	Magda Fassbind e r	
2 sho and the		ing Address (Street and Number or Rural Route Number	, City or Town, State, Zip Code)
	Marshall Muller / Son 3134	Port Way Amapolis, Mar	vland 21403
0 0 = =	20a Method of Disposition 120h Place of Dispo		oc. Location - City or Town, State
permil. Pages Department of I Important: If Its sny injury or o	'4 □Donation 5 □Other (Specify) Metro Cre		Baltimore, Maryland
permit. Departrimports Eny inju	21. Signatura / uneral Say ce life niee 22	2. Name and Address of Facility John M. Ta	ylor Funeral Home, Ir
00 = 0 a		147 Duke of Gloucester St.	
Physician	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a	ler the mode of dying, such as cardiac or respiratory arre	Interval Between Onset and Death
/Medical	resulting in death) a. Due to (or as a consequence of):	(IN IN O TO)	minuje
Examiner	Sequentially list conditions. b. Coronary ar	tery distase	years
P # C	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	
executed in and ial-transit	Cause (Disease or injury that initiated events resulting in death) Last	<u> </u>	years
ate be executed hysicien and the burial-transit	d. hyperlip i Le		1/0 - 00
physicie but s the but	d. rype corp 1 ce	ma	years
the death certificate be executed by the attending physicien and ached for use as the burial-transit hysician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
w requires that the deben signed by the should be detached leted by Physic	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 23e. Did tob	acco use contribute to the cause of death?
equire	atrial tibrillation, bradyc	ardia requiring 10 Yes	s 25No 3 Probably 4 Unknown
8 2 C D	cacemaker, ventricular tec	hycardia, 0 24a. Was an autopsy	/ prior to completion of cause of
cate , pag	nonagenarian	perform 1 □ Yes 2	death? Y No 1 ☐ Yes 2 ☐ No
raician: The law s certificate has t lirector, page 2 s	25. Was case red red to medical examiner?	26. Place of Death (Check only one	3)
Physical direction of the control of	1 Inpatient 2 ER/Outpatien		7
ding h. After fune	27. Magner of Death Natural 5 ☐ Pending (Month, Day Year) ☐ Accident investigation	28c. Injury at Work? M 1 Yes 2 No	w injury occurred Living
Attender deal	3 Suicide 6 Could not be		eet and Number or Rural Route Number.
ital or Attending P at after death. all Director: After led in by the funera Certification;	4 Homicide determined building, etc. (Specify)	City or Town,	State)
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death (Check only one) Certifying Physician: To the basis of examination and/or invariant manner stated.	n occurred at the time, date and place, and due to the car restigation, in my opinion, death occurred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
Io the	29b. Signature and title of certifier	29c. License number 29	ld. Date signed (Month, Day, Year)
275	mayer	TINO -	26 01/
	0. No me and address of per so who completed cause of death (Item 3. (Typ.)	Print)	Jule sville 10
	pelsona Don MI 801 Vere	ign sttinhwow 4204	2110
State	3 Date filed (Month, Day, Year) 32. Registrar's Signature		
Registrar	MAR 1 0 2004	Borelle	

		artment of Health and Mental Hy rtificate of Death	
Physician /Medical	Decedent's Name (First, Middle, Last) Alice Adele Miller	2. Date of Di Month Www.	Day Year
Examiner	4a. Fecility Name (<i>If not institution, giv</i> e street and number) North Arundel Hospital	4b. City, Town, or Location of Death Glen Burnie	4c. County of beeth Anne Arundel
Funeral Director	5. Social Security Number 218-34-8057 6. Sex 1 M 2 M F 66 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Bit Months Days Hours Min. NOV.	9. Birthplace (State or Foreign Country)
Maryland show list at	Usuat Residence of Decedent 10a. State	ocation Severna Park	10d. Inside City Limits 1 ☐ Yes 2X No
of the man of the maryland of the man of the confident of	10e. Street and Number 94 Eastway	101. Zip Code 21146	10g. Citizen of What Country?
<u> </u>	1 Never Married 2 Married 1 ☐ Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or Not the Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours all postment of Health and Mental Hygiene. portant: If Itan 271s marked other than "natural", or yinjury or other traumatic event, tra Medical Example. To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2	dent's Usual Occupation kind of work done during most of working DO NOT use retired) Homemaker	16b. Kind of Business/Industry Home
Viand Syland Syland Mental Hyg	17. Father's Name (First, Middle, Last) Granville Wolf Wilson	18. Mother's Name (First, Middle Ruth Luthy	
Mary and 2 sho alth and h		ng Address <i>(Street and Number or Rural Route Numb</i> Eastway, Severna Park, M	
More, lamber of them fury or other	I Dunar 2 XICremation 3 I Hemoval from State	sition (Name of natory or other place) Trematory 2004	20c. Location - City or Town, State Baltimore, MD
Balt permit. Depart Import eny inju	B	2 Name and Address of Facility arranco & Sons, P.A. Seve 95 Gov. Ritchie Hwy, Seve	erna Park Funeral Home
cate be executed by year and physician and the burial-transit the burial-transit dical Examiner	23a. Pagr. Enter the disease, or complications that caused the death. Do not ent spock, or heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	noumon) A	Onset and Death
S, P.O. Box 687(es that the death certificate Ingred by the attending physibe detached for use as the by Physiclan/Medica		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
rds, P quires that on signed b uid be deta	Part II. Other significant conditions contributing to death but not resulting in the un		obacco use contribute to the cause of death? Yes 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{VUnknown} \)
al Record The law requir cate has been s page 2 should			
Division of Vital Records, P.O. Box 687 tall or Attending Physician: The law requires that the death certificate is after death. The law requires been signed by the attending physician by the funeral director, page 2 should be detached for use as the Certification; To Be Completed by Physician/Medic.	25. Was case referred to medical examiner? 1		
Division To the Hospital or Attention Within 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, strubuilding, etc. (Specify)	City or Tou	
Div To the Hospital or within 24 hours after To the Funeral Dir completely filled in I	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death (Check only one) Certifying Physician: To the best of my knowledge, death (Check only one) Medicel Examiner: On the basis of examination and/or invanient of the best of my knowledge, death (Check only one)	estigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)
Toon Toon	29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed gause of death (ttem 23a) (Type, Auckin DKETUMT), 30 HATEL DRIVE, 6 UN		March 4 2001.
State Registrar	31. Date filed (Month, Day, Year) MAR 0 9 2004	hall	

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First_Middle, Last) 2. Date of Deeth **Physician** 105e /Medical 4b. City, Town, or Location of Death 4a Facility Name of not Institution, give street and humber, **Examiner** (olum) Howard 0447 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | November 29, 1925 | Virginia 7. Age (In yrs. last birthday) 78 Yrs. 5. Social Security Number **Funeral** 1**X**]M 2□ F Months 579-24-8430 Director Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Merylend nent of Health end Mentel Hygiene. ant: If item 27 is marked other than "naturel", or items 23e or 28a-f show ury or other traumetic event, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits District 1X Yes 2 □ No **Funeral Director** Of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4651 Nannie Helen Burrough Ave. Apt 102 USA 20019 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 No 3altimore, Maryland 21215-0020 Specify Be Completed by 3 N Widowed 4 Divorced 16a. Decedent's Usual Occupation . (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NIH Janitor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Napper Mable Hansberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7403 Brixworth Court Apt, 103 Baltimore, Maryland 21244 Depertment of Health er Important: If item 27 is any injury or other trau Diane Kent/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico National Cem 3/17/04 Triangle, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Nama and Address of Facility dessa MO1323 Adams Funeral Home P.A. Aquasco, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Yes 24 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 ☐ Yes 2 ☐ No this After this funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funerel Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide the Hospital 29a. Certifier 114 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) K42/34 10805 Hickors Gara 31. Dete-filed (Month, Day, Year) State MAR 1 5 2004 Registrar

			1 - For State Registrar	State of Maryland	/ Depa		lealth and		_	
	Physici /Medio	al	1. Decedent's Name (First, Middle), Last, Mil dve d As Escility Name (If not institution, give	A. Newso	.hle		s Langtion of D	2. Date of Dea Month O '3	Day Ye	1-45PM
	Examin Funeral Director	ier	4a. Facility Name (If not institution, give 918 Shipmaster Ct. 5. Social Security Number 6. Sec. 062-09-9811		st birthday) Yrs.	Anna If Under 1 Year Months Days	polis If Under 24 F		Anne A	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Unportant: If item 27 is marked other than "natural; or items 23e or 28e-f show any injury or other traumatic event. It is Michael Examiner must be notified at 206e.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. Slate 10b. County Maryland Anne Art 10e. Street and Number 918 Shipmaster Ct. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify) 15. Decedent's Edu (Specify only highest grade (Specify) 16. Decedent's Edu (Specify) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Ty Edward J. Neuschl 20a. Method of Disposition (Specify) 21. Signatur of Funeral Shryice Licensi	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: cation e completed) College (1-4or 5+) pe, Print) er/ Husband lemoval from State 20b. Pla cent Lake	19b. Mailir 918 ce of Disponetery, crere	Innapolis 10f. Zip Code 21. Was Decedent of H 1 Yes, specify Cuba in Yes 22 No John Yes 22 No John Yes 22 No John Yes 25	ation during most of of the state of the sta	(Specify Yes or No- erto Rican, etc.) working Name (First, Middle, I Mary Mont Rural Route Number Annapolis Date	Black, V Specify: 16b. Kind of Busine Ho Maiden Surname) Lague City or Town, State MD 2140 20c. Location - City Davidsonv Kalas Fur	American Indian, White, etc. White Description White Description White Description White Description White White Description White
760,	Physician // Medical Examiner We burial-transit Physician and Phy	cal Examiner	23a. Part1. Enter the disease, or complished, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	eloice of):				est,	Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	3c. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea	eath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	ne law requires tha has been signed ge 2 should be de	Completed by P	Part II. Other significant conditions con	tributing to death but not resulti	ing in the ur	derlying cause givi	en in Part I.	1 ☐ Ye	n 24b. Ware	a to the cause of death? Probably 4 Unknown autopsy findings available to completion of cause of
Division of Vital Records,	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification; To Be Co.	27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be	The second of	R/Outpatien 8b. Time of Injury	28c. Injun Worl M 1 []	er: 4 🗌 Nursing	peath (Check only only only only only only only only	θ) nnce 6 Other (Sow injury occurred	′es 2□ No
Div	To the Hospitel or A within 24 hours after to the Funerel Directompletely filled in by	Medical Certif	29a. Certifier (Check only one) 29b. Signature and title of certifier	building, etc. (Specify) sician: To the best of my knowleer: On the basis of examinatio and manner stated.	edge, death	occurred at the tim	pinion, death oc	ce, and due to the ca	t, State)	as stated. due to the cause(s)
	Sta Registr	te	30. Name and address of person who co		100	000	5917	3	03-11-	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend 20 per F.H. g830 4/1/04 KB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Nelson March 425 PM /Medical 2004 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore If Under 24 Hrs. 5. Social Security 219-65-4466 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1□M 2001 Months Days Hours Min Yrs. Director Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore MD 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: 2 Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. pO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Dapartment of Health and Mental Hygiena. Important: if Item 27 is marked other than any injury or other traumatic event, the Ms Elementary/Secondary (0-12) College (1-4or 5+) 17 Father's Name (First, Middle,:Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should nent of Health and Men 19a. Informant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City of Town, State, Zip Code) mother 20b. Place of Disposition (Name cemetery, crematory or oth DateO4 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 21. Signature of Foneral Service Licenses the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, heart failure. List only one cause on each line. **Physician** Immedia e Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner or Attending Physician: The law requiras that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Adenomatoid Malformation 13 months Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 Probably 4 ☐ Unknown ۵ Division of Vital Records, page 2 should be 24b. Were autopsy findings availeble prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 ☐ Yes 2100 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examina??
1 □ Yes 2 □ No funaral director, Be 26. Place of Death Check on one Hospital: 1 Impatient Other: 4 Nursing Home Medical Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 3 Suicide 6 ☐ Could not be determined within 24 hours aftar de To the Funeral Directo completely fillad in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0038127 of death (Item 23a) (Type, Print) SINAI Hospital 2401 West Balvedore Avenue Baltimore MD

32. Registrar's Signature

Registrar

State

31. Date filed (Month, Day, Year)

2004

			For State of Registrar	Maryland / Dep	ertificate of De	Ith and Mental Hy	ygiene 2004 10445
	Physici /Medi		. Decedent's Name (First, Middle, Last) Sylvia Barlly O'Mara			2. Date of D Month	Day Year
	Examir		ia. Facility Name (If not institution, give street and num PON) NSU/A_RIGIONNO/_MIGUITE		4b. City, Town, or Loca	/ /	4c. County of Death
	Funeral Director			7. Age (In yrs. last birthda) 83 Yrs.	/) If Under 1 Year If U		9. Birthplace (State or Foreign 15, 1920 IIII nois
0	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	_ocation		10d. Inside City Limits
6116	e Mary Be-f sh	ctor	Maryland Dorchester	Camb	oridge		1 □ Yes 🎉 No
2	38 or 2	i Dire	10e. Street and Number 103 Map1e Avenue		10f. Zip Code 216	13	10g. Citizen of What Country? USA
10-2	11215-0036 CLRS within 72 hours after death with the Maryland ene. than "natural", or tems 23e or 28e-f show the Maryland in M	y Funeral Director		2 € No	_	nic Origin? (Specify Yes or Nexican, Puerto Rican, etc.)	Specify:
06	Maryland 21215-0036 nd 2 should be filed within 72 hours affer than Mental Hygiene 27 is marked other than "natural; or is treumatic event, the Medical Experience.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	16a. Dec (Giv life.	edent's Usual Occupation e kind of work done during DO NOT use retired)	g most of working	White 16b. Kind of Business/Industry
	d 21 filed will Hygien other th	Con	17. Father's Name (First, Middle, Last)	Pro	oof Reader	Mother's Name (First, Middle	Book Binding Manufacture Book Binding Manufacture Book Binding Manufacture Book Binding Manufacture
7	farylanc	To Be	Martin J. Barlly			Katherine Bor	
Silsin O'mane	Baltimore, Maryla Dermit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other treumatic once.		19a. Informant's Name/Relationship <i>(Type, Print)</i> Kathleen O. Tieder/Daugh	iter P.O.	ling Address (Street and A Box 126, T	Number or Rural Route Numb aylors Island	ber, City or Town, State, Zip Code) I, MD 21669
0	Baltimore, permit. Pages 1 ar Department of Hea mportant: If item: iny injury or other DOG.		20a. Method of Disposition 128 Burial 2 Cremation 3 Removal from S	20b. Place of Disp cemetery, cri	position (Name of ematory or other place)	Date	20c. Location - City or Town, State
Silse	Baltimo permit. Pag Department Important: I any injury o		^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee			3/12/2004 Fally Funeral H	Hurlock, Maryland
0	o aassa		23a. Rant Enter the disease, of complications that a shock, or heart failure. List only one cause on ea	used the death. Do not e	308 High Str	eet, Cambridg	e, MD 21613
•	Physician /Medical		Immediate Cause (Finaf disease or condition resulting in death)	RENTE	FAT Love		Onset and Death
	Examiner			or as a consequence of):	5		
	uted d ansit	Examiner	Sequentially list conditions, Due to coause. Enter Underlying Cause (Disease or injury that initiated events c.	r as a consequence of: V7			
	68760, filicate be executed physician and ts the burial-transit		resulting in death) Last Due to (c	r as a consequence of):			,
		ledicai	d				
	Division of Vital Records, P.O. Box 68 or Attending Physicien : The law requires that the death certifica after death. Director: After this certificate has been signed by the attending phore to the funeral director, page 2 should be detached for use as it in by the funeral director, page 2 should be detached for use as it.	Physician/Med	in the past 12 months?	nt at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	cords, P. wrequires that been signed be detailed to should be detailed.	þ	Part II. Other significant conditions contributing to dea	ath but not resulting in the	underlying cause given in		tobacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 ☑ Unknown
	A Reco	Completed	MV4			perf	s an 24b. Were autopsy findings available prior to completion of cause of death? 2 🗸 No 1 🗀 Yes 2 🗆 No
	f Vital Pyeicien: The is certificate director, pag	o Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospitaf: 1 In	/	Other	Place of Death (Check only	one)
	ion of nding Phyenth. After this e funeral di	 -	27. Manyer of Death 28a. Date of	patient 2 ER/Outpatie Injury 28b. Time , Day Year) Injury	AIL SEI DOA 4	28d. Describe	idence 6 Other (Specify) how injury occurred
	Divisio To the Hospitel or Attend within 24 hours after death To the Funerel Director; completely filled in by the f	Certification:	3 Suicide 6 Could not be determined 28e. Pface buildin	of Injury - At home, farm, s g, etc. <i>(Specify)</i>	treet, factory, office		(Street and Number or Rural Route Number, wm, State)
	Div To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the la 2 Medical Examiner: On the ba and mann	sis of examination and/or i	ath occurred at the time, da nvestigation, in my opinior	ate and place, and due to the n, death occurred at the time	, date and place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		29c. License nun		29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause	of death (Item 23a) (Type	Print)	5T 3471168	3/6/04 LUNY ND 2,804
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Re MAR 0 8 2004	gistrar's Signature	book		· /

•			For State Registrar		State of Ma	arylan	d / Depa <i>Cei</i>	artment of Hertificate of D	ealth and N Death	Mental Hygi	ene 2	004	1044
1	Dhyois	on	1. Decedent's Name (First,	Middle, Lasi	")					2. Date of Death		Voar	3. Time of Death
	Physic /Medi		FLOYD		RICHARD		OTZE	BERGER		March	28,	ްÖ'04	10:30 AM
7*	Exami	ner	4a. Facility Name (If not inst	-				4b. City, Town, or				ty of Death	
	- 1 <u>2</u>		7318 Shar 5. Social Security Number	6. Se		e (lo vrs. l	last birthday)	Boons If Under 1 Year		8. Date of Birth	Wa	shing	
162	Funeral Director		220-30-9985		M 2□F	74	Yrs.	Months Days	Hours Min.	(Month, Day,)	9,19		lace <i>(State or Foreigr</i> <i>try)</i> laryland
			Usual Residence of Decede	nt						MPITI Z	0,10	40 1	iai y i aiiu
arylar	show tal	-	10a. State 10b. Co	•		,	y, Town or Lo					10	Od. Inside City Limits
he M	Ba-f	acto		asnıı	ngton	B	Boonst						1 ☐ Yes 2√ No
with t	be or	급	10e. Street and Number 7318 Sharp	chur	a Dika			10f. Zip Code 21713		10		f What Coun	try?
leath	ns 23	era	11. Marital Status	3001	12. Was Decedent	Ever in U.	S. 13. V		panic Origin? (Sp	ecify Yes or No-	U . S	A. A.	an Indian.
G Z I Z I S-UU30 ifled within 72 hours after death with the Maryland	nal hygiene. nd other then "natural; or Itams 23a or 28a-f show event, the Medical Examenat mai be notified at	by Funeral Director	1 Never Married 2 3 Widowed 4 □ Divi	1	Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			Vas Decedent of His f Yes, specify Cuban I □ Yes 2 🕱 No		Rican, etc.)	ВІ	ack, White, e	etc.
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should	d Me mark matic	2	19a. Informant's Name/Reia		Otzelbe	rgei		g Address (Street ar	Aleta	Ardel		Byrd	
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ָבֶּ עַ מַ	Hea Item		20a. Method of Disposition		,	20b. PI	lace of Dispo:	sition (Name of natory or other place	1			- City or To	
Pages	ent of nt: If if ry or o		1 X Burial 2 ☐ Crema 14 ☐ Donation 5 ☐ Oth					.1 Cemeter		0-04	Janer	stown	Maryland
permit. Pages 1 a	Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once.		21. Signature of Funeral Se				22	Name and Address Idrew K. C East Ant	of Facility				-
J.S.	-111		23a. Part1. Enter the disease shock, or heart failure.	se, or comp	lications that caused	the death	. Do not ente	or the mode of dying,	such as cardiac	reet, Hac or respiratory arres	jersto		Approximate
Ph	ysician		Immediate Cause (Final	cist only o	The cause on each in	4		A	10/ 000	1			Onset and Death
//\	Medical		disease or condition resulting in death)		Due to (or as	a consequ	ience of):	andial	Parc	cen	-	C) pours
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cate be exe	cien a	E			Due to (or as	a consequ	ienogrot):	10					10201
cate	physics the	dlcal		•	d1	mo	sau	1575					Jern.
The law requires that the death certificate be executed	attending pl	lan/Me	IF FEMALE:	. 2	23c. If yes, outcome	of pregnar	ncv				224 0	ata of dalises	
eath D	atter I for u	clar	23b. Was decedent pregnar in the past 12 months?	ц	1☐Live birth 4☐Pregnant at	2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)			1	ate of deliver onth	y Day Year
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duire	been sig should b		Degl	hra	live as	Thm	145			1 ☐ Yes	2 No	3 🗌 Proba	bly 4 □Unknown
a S ¥	2 sho	Completed	Congr	(stri	in his	N -	Parler	AD .		24a. Was an	24b.	Were autop	sy findings available
The	page 2	E O	0		-					autopsy performe 1 Yes 2		prior to com death? 1 \(\text{Yes} \) 2	pletion of cause of
Attending Physician:	r this certificate ral director, pag	Bec	25. Was case referred to me examiner?	dical					26. Place of Death	Check on one)	(110		
hysic	w =	은	1 ☐ Yes 2 No	H	lospital: 1 Inpatie	nt 2 🗆 E	ER/Outpatient	3□ DOA Other	4 Nursing Hor	ne 5 Residend	e 6 □Ot	her (Specify)	
To Attending Physician: The law requires the	e te	on:	27. Manner of Death 1 Natural 5 □ P	ending	28a. Date of Injur (Month, Da)	Year)	28b. Time of Injury	28c. Injury a Work?	at :	28d. Describe how	injury occu	rred	
tend	deatn. stor: After thi r the funeral o	cat	2 1 100100111	vestigation ould not be	n Di (1)				es 2 No				
Or A	Dirac Dirac I in by	ertification:	4 ☐ Homicide de	etermined	28e. Place of Injubulding, etc	Specify	me, tarm, stre	et, factory, office		28t. Location (Stree City or Town, S		ber or Rural	Route Number,
To the Hospital or	within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical C	29a. Certifier Cer (Check only 2 Med	tifying Phy iicai Exami	sician: To the best oner: On the basis of and manner sta	examinati	vledge, death ion and/or inv	occurred at the time estigation, in my opin	, date and place, a	and due to the caused at the time, date	se(s) and m	anner as sta and due to t	ted. the cause(s)
o the	ompli	Me	29b. Signatural and title of ce	ertifier				29c. License i	number	29d	Date signe	ed (Month, D	ay, Year)
μ:	0		125	1				1449	96			29,	
٢	<u> </u>		30. Name and address of pe	rson who co	ompleted cause of de	eath (Item	23a) (Type. F						
_			Zafar M.					s Road, B	oonsboro	, Marylan	d 217	13	
	Sta		31. Date filed (Month, Day,	(ear)	32. Registra	r's Signati	ure				T		
	Registr	ar		IPR 0	6 2004	HELMOON A.	. K	1031 E. 3	4				
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ORIGINAL

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	Dhusiai	n Mar	1. Decedent's Name (First, Middle, La	st)						Date of Death Month	Day Ye	ar	ne of Death
	Physici /Medic		Eva Louise Ph							Jarch		7 7	34 M
100	Examin	er	4a. Facility Name (If not institution, giv			10.10		n, or Location of SAL 156			4c. County of I	OMICO	
	<u> </u>	38	FENINGULA SEGION 5. Social Security Number 6.5		7. Age (In yrs.		If Under 1 Ye			Date of Birth Month, Day,			tate or Foreign
41°	Funeral Director			I □ M 21XF	67	Yrs.	Months Da	ys Hours	Min. Ju	(Month, Day, $11y 27$,	1936 De	Country)	
100	0		Usual Residence of Decedent									1.04.1-1	de City Limits
0	arylan show	_	10a. State 10b. County			y, Town or Lo							Yes 2 No
2	Ba-f s	ecto	Maryland Wicomic	0	Sa.	lisbury		40		10	g. Citizen of Wha		
3	with I	늅	10e. Street and Number 220 Records Stree	+			10f. Zip Coo			10	USA	it Couriny?	
)	eath	Funeral Director	11. Marital Status		edent Ever in U	.S. 13. V		of Hispanic Orig Cuban, Mexican	gin? (Specify	Yes or No-	14. Race -	American India	an,
10	fter d	표	1 Never Married 2 Married	Armed F	orces? 2⊠No				, Puerto Rica	in, etc.)		White, etc.	
ဗ္	rai', o	þ	3 \ Widowed 4 □ Divorced	If Yes, G Year or I	ove Dates:		TU Yes 2LA	No Specify:			Specify:	Whit	e
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Exercine must be notified a	Completed	15. Decedent's E (Specify only highest gr			(Give	tent's Usual Ockind of work do	one during most	t of working	1	6b. Kind of Busin	ess/Industry	
7	han han	mpi	Elementary/Secondary (0-12)	College	1-4or 5+)		DO NOT use re Lter	atirea)			Eldercar	-e	
7	Hygie thar t		8 17. Father's Name (First, Middle, Las	')		DI		18. Mothe	r's Name (Fi		faiden Sumame)		
au	d be ental	To Be	Darcy C. Brasure					E1s	ie Dor	ev			
Maryland	shoul nd Mari mari	-	19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	ng Address (St				City or Town, Sta	te, Zip Code)	
ž	aith a		Tammy Peek/Daugh	ter					, Sali	sbury,	Marylar	nd 218 <u>0</u>	4
ore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 〔	VDamoval from	20b. F	Place of Dispo cemetery, cren	sition (Name o	place)	Date	2	Oc. Location - Cit	y or Town, Sta	ite
Ĕ	Page nent ent: If ury o		'4 □Donation 5 □ Other (Speci		Red	lmen Me	morial	Cem. 3	3/14/20	004 I	agsboro		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23a or 28a-f ahow amy injury or other traumatic event, the Medical Examiner must be notified at ance.		21. Signatur of Funeral Service Lice	1 00	.00,	Ze Ze	Name and A	ddress of Facility uneral	Home,	P. O.	Box 3171 alisbury	,	
_	70 E B 9		Jamaico 1										1802 ximate
В			232 Part. Enter the disease, or conshock, or heart failure. List only	one cause on	each line.		er the mode of	dying, such as	cardiac or re	spiratory arre	51,	Interva	al Between and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		tralial	Inf	arch				1/2	.hr
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4,,		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consec								
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o,	be executed ician and burial-transit	EX	resulting in death) Last	Due to	(or as a consec	quence of):							
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x 68	death certificat e attending phy id for use as th	Physician/Med	IF FEMALE:	230 If ups o	utcome of pregna	2004					204 D-1-	f delices	
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	1 🗀 Live	birth 2 ☐ Feta mant at time of c	aideath 3 🗀	Ectopic pregn Other (specif				23d. Date of Month		Year
o.	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk		30401 3	J Cities (Special	,,					
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rds	quires t n signe uld be		Obesity							1 □ Ye	s 2 □ No 3[Probably	4 Unknown
Vital Records,	aw requii as been s 2 should	ompleted	Hyperter	13700						24a. Was an		re autopsy find r to completion	dings available
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ital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?	E		/			of Death C	heck onle one	9		
× ×	8 S D	2	1 ☐ Yes 2 ☑ No			ER/Outpatier					nce 6 Other	(Specify)	
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isi	De or	icat	2 Accident investigation 3 Suicide 6 Could not	be Jan Blad	e of Injury - At h	ome farm str				Location (Str	reet and Number	or Rural Route	Number,
Division of	atter Direction by	Certification:	4 Homicide determine		ding, etc. (Speci					City or Town	, State)		
	To the Hospitel or Atti within 24 hours after de To the Funeral Directo completely filled in by th										use(s) and mann		
	n 24 l n 24 l he Fu	edical	(Check only 2 Medical Exa		hasis of examining nner stated.	ation and/or in	vestigation, in	my opinion, dea	ith occurred a		ate and place, and		
	To the within 2 To the complet	Σ	29b. Signature and title of certifier					cense number			d. Date signed (/	Month, Day, Ye	∍ar)
7			of Coper	0			1-	100156	97		3/11/57		
			30. Name and address of person who	completed ca	use of death (Ite	m 23a) (Type,	Print)	5 . 1 . 1	N	1/ 3/	XOI		
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	Regist		MAR .	1 6 2004	Been	u K	Road	م					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item#26 State of Maryland / Department of Health and Mental Hygiene 1- State per Phy. 3/16/04 BEM Registrar AACo. Health Dept. Certificate of Death Reg. No. Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Vear Mary Margaret Prince 2004 12 12:15 A /Medical March 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Sunrise Assisted Living Annapolis Anne Arundel If Under 1 Year I tf Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 200 F **Director** Nov. 15, 1910 438-52-7978 93 Louisiana Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show s 23a or 28a-f show 1 ☐ Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 3753 Thomas Point Road 21403 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. The Medical Examiner filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify 3 Widowed 4 □ Divorced white "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home of Health and Mental Hygie litem 27 is marked other i r other traumatic event, III other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental ပ Margaret Sherman Joseph Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a : If item 27 is or other train 3753 Thomas Point Road Annapolis, MD 21403 Ginger From/ daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If any injury o * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory March 13, 2004 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Komanoch 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death DNOX Heart **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or intury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and the burial-transit Box 68760, Completed by Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached fo Records, P.O. 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 @Unknown should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has the irector, page 2 s autopsy performed? 2 No 1 ☐ Yes Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one 5 Residence 6 Other (Specify 1 V1) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 1 Yes 2 No Medical Certification: To this After the funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Naturat 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Mohth, Day, Year)

MAR 1 6 2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Katherine N. Payne 8 2004 March 9:50 pm * /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Nursing & Rehab. Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Yrs. Director June 14 1917 215-12-4242 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 XYes 2 No Director Maryland Anne Arundel Annapolis 10e. Street end Number 10g. Citizen of What Country? Funeral Street 21403 McKinley USA 1305 N. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Black þ 1 ☐ Yes 2 No Specify: Specify: **∄**☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12th 4 yrs. Procurment Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isabell Foskey John Plummer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2333 78th Ave. Phila., Pa. 19150-1811 Harriet A. Staten (GOd-daughter) 20b. Place of Disposition (Name of cemetery, crematory or other plece)
Beverly National 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 3/17/04 Beverly, New Jersey 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wm. Reese & Sons MOrtuary, P.A. 23a. Part1. Enter the distase, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. St. Annacolis Md. 21401
Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner led by the attending physician and detached for use as the burial-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other-significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? been signed by I should be detact 1 Yee 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed TL Yes 22No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending P s efter death. I Director: After is of in by the funer. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours eff To the Funerel DI completely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division of Vital Records, P.O. Box 68760

State Registrar

29b. Signature and title of certifier

GRON BORIS 31. Date filed (Month, Day, Year) strar's Signature MAR 1 5 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RADIO PAICK

work

29c. License number

SUITE 230

29d. Date signed (Month, Dey, Year)

OUSON MD ZÍZ86

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year 0330 M MARCH 16 ,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solisburg Kegional Medical Center Wiconico eninsula 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 215-62-0523 Days 1**∭**M 2□F Hours Min 50 Director Md Usual Residence of Decedent 10a. State 10b. County City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Markeal Examinar must be natified at Pocomoke 1 Yes 2 No Completed by Funeral Director Worcester death with the 10g. Citizen of What Country? 508 21851 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give 7 Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. illed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: BIACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. onstr Elementary/Secondary (0-12) College (1-4or 5+) FINISHER ement Indus Pages 1 and 2 should be file timent of Health and Mental Hy lant; If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) herrie Kevel 20b. Place of Disposition (Name of cemetery, crematory or other place) Pocomo Ke City, Md 21851 Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, State permt. Pages Department of Important: If it any injury or o 1 X8urial 2 ☐ Cremation 3 ☐ Removal from State 3/20 Mt. Sinai Church Cemeters of Facility
22. Name and Address of Facility 4 ☐ Donation 5 ☐ Other (Specify) 104 Pocomoke, Maryland 21. Signature of Fucarri Service Lio Bennie Smith 819 Fourth St. Pocomoke, md 21851 FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Hypoxemia
Due to (or as a consequence of): Physician 2 was Ks /Medical Examiner J. weeks Phenmonia Sequentially list conditions, if any, leading to immediate causs. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Lung concer with Brain Metastasis 11 months burial-tran Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? peq millitus 1 Yes 3 Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 2 No 24 hours after death Funeral Director: A 2 Accident 1 Tyes 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Seyod A 100000412 mark, 16,2004

State Registrar

DHMH 17 Rev 1/2001

REVEL

State 31. Date filed (Month, Day, Year) MAR 1 7 2004

Seyed A. Jalali

100 East carroll st

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salisbury, mp 31701

PARALL

			1 - For State Registrar	State of Maryland	•	rtment of H			giene Reg. No.	2001	10451
	Physici	20	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic		Herndon	Barbo	ur	Rudasil		March	9,	2004	1:25P M
8	Examin	er	4a. Facility Name (If not institution, give s Malcolm Grow Ho			4b. City, Campi Andrews	Springs Air For	s, rce Base		County of Deer	George's
	Funeral Director		5. Social Security Number 6. Sex 17. 17. 17. 17. 17. 17. 17. 17. 17. 17.	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		, Year)		thotace (State or Foreign buntry) shington DC
	yland now		Usuat Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	ation					10d. Inside City Limits
	e Mar	ctor	Maryland Prince Ge	orge's F	orest	ville					1 ☐ Yes 2X☐XNo
	with the	Funeral Directo	10e. Street and Number 8000 Richard Dri	ve		10f. Zip Code 20747	,			zen of What Co	ountry?
	death ms 23	nera	11. Marital Status	12. Was Decedent Ever in U.S.	13. W			Specify Yes or No- to Rican, etc.)		14. Race - Ame	
326	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or itams 23a or 28a-f show event, the Medical Exerties must be rediffed at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No 1935— If Yes, Give 1935— Year or Dates:		Yes, specify Cuba	Specify:	to Hican, etc.)		Specify: White	
Š	72 hou	ted	15. Decedent's Edu		6a. Deced	ent's Usual Occup	ation	adria =	16b. Kir	nd of Business/	
21215-0036	within 7 ene. than "r	Completed	(Specify only highest grade	College (1-4or 5+)	life. D	ind of work done o O NOT use retired iirman	during most of wo		C&P	Telepho	ome Co.
2	ntal Hygie ed other	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,			J. 100.
Maryland	should be and Mental marked umaric ev	To B	Herndon B. Rud	asill			Mary N	1. Unswor	thy		
	2 1 2 2		19a. Informant's Name/Relationship (Ty) Rose G. Rudasill	(Wife)				ural Route Numbel restvill			
ore,	es 1 and of Healtl if Itam 2 rr othar 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b. Place	of Dispos	ition (Name of atory or other plac	Marc	hat 13.200	20c. Lo	cation - City or	Town, State
Baltimore,	permit. Pages 1 Department of H Important: if its any injury or ot		*4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral → vice Livense	St. P	eter'	s Cathol	ic Churc	ch Cem. ee Funer	Walf	orf, Ma	aryland
n	Depa Impo any i		Lavio A. Aran	4 moo257	66	33 01d A	lexandri	a Ferry	Road	Clinto	on, MD20735
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Finat	cations that caused the death. D	o not ente	r the mode of dyin	g, such as cardia	c or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	/ 7 ce of):	nopres	TON				Mins
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	acuted nd transit	Examine	that initiated events								
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ion	r Attending Per death.	atio	1 XNaturat 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Intury		:? /es 2 □ No				
DIVISION		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (St City or Town			ral Route Number,
	To the Hospital of within 24 hours at To the Funaral D completely filled in	edical (29a. Certifier 1 To Certifying Physics (Check only one) 2 Medical Exemination	ician: To the best of my knowled ter: On the basis of examination a and manner stated.	ige, death and/or inve	occurred at the timestigation, in my op	e, date and place pinion, death occu	e, and due to the caurred at the time, da	ause(s) a ate and	and manner as place, and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	4-1.	_	29c. License		25	9d. Date	signed (Month	i, Day, Year)
			NZSumy Z	Frelow	(II)	D0019	23	-	Ma	vek 1	10,2004
1	3851		30. Name and address of person who con Thomas L. Fie		a) (Туре, Р Craiı	_{rint)} n Highway	Waldor:	f, Maryla	nd 2	20601	
	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 1 2, 26	32. Registrar's Signature	y. A	hertes			-		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item#14 per Fun.Dir. 3/16/04 BEM Certificate of Death ACo Health Dept 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician ROSE Year ROSS E11en March 15, 2004 2:00 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent & Rehab Center Crofton Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year) May 27, 1946 Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2₩F 405-66-4372 57 Yrs. Director Kentucky Usuel Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at 10d. Inside City Limits Prince Georges Director Maryland Bowie 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13117 Crutchfield Avenue 20715 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status pernit. Pages 1 and 2 should be filled within 72 hours after Capartment of Health end Mentel Hygiene. Important: if Item 27 Is marked other than "natural", or its any injury or other treumatic event, the Medical Exemine Any Injury or other treumatic event, the Medical Exemine 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No altimore, Maryland 21215-0020 1☐ Yes 2√2 No Specify. þ Specify: White Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lee Hatchett, Jr. Carrie Buckner ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerald D. Baker/ Son 13117 Crutchfield Avenue, Bowie, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Eremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/17/04 Waldorf, Maryland Huntt Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Egyclio Vas Cular Distax Physician/Medical Examiner ettending physicien and for usa as the burial-transit or Attending Physician: The lew raquiras that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 2 0 No 1 ☐ Yes 2 ☐ No ours after deeth.

eral Director: After this certificatile in by the funerel director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Medicai Certification: To 1 ☐ Yes 2 🗷 🗘 🔾 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1. Natural 28c. Injury a Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Fune completely fi 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Rakesh Arora, M.D.
31. Date filed (Month, Day, Year)

MAR 1 6 2004

& Specific

32. Regisfrar's Signature

14300 Gallant Fox Lane Suite 222, Bowie, Maryland

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Mar. **Physician** John Rutledge, Jr. 2004 5:34 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 24 Hrs. 8. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Days Min 1 XM 2 ☐ F Director 77 Yrs. 415-28-0349 21, 1927 TN Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked othar than "natural", or items 23a or 28a-f shor traumatic event, the Madical Examinar must be notilied at MD Anne Arundel Severna Park 1 ☐ Yes 2X No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10 Carole Court 21146 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⅓ Yes 2 □ No 195 If Yes, Give Year or Dates: 197 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1950-White 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify δ 3 ☐ Widowed 4 ☐ Divorced 1970 Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) U.S. Army Lieutenant Colonel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othany injury or other traumatic event Be Tula Randolph John Rutledge 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois S. Rutledge/Wife 10 Carole Court, Severna Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Mar. 16 Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2004 Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licensee 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physiclan/Medical Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? Common Variable Immunode ficie 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 □ No þ 24b. Were autopsy findings available prior to completion of cause of death? 24 Was an autopsy Completed 1 🗆 Yes 1 ☐ Yes 2 ☐ No isonso 25. Was case referred to predical examiner? Be 26. Plece of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 3 LOA 2 ER/Outpatient After this 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? he Hospital or Attending Pl in 24 hours after death. he Funaral Diractor: After th 28d. Describe how injury occurred Certification: 1 1 Hitural 2 Accident 5 Pending investigation 1 🗌 Yes 2 🗆 No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dertifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and cut to the naute(s) and manual as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifier (Check only one) within 2 To the I To the 29b. Signature and title of certifier 29c. License number

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2004

State Registrar 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Gloria Porter Scott March 1:17 P 13, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Atlantic General Hospital Worcester Berlin If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🙀 F Yrs. 489-24-2337 Director 79 July 13,1924 Florida Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "neturel", or Items 23e or 28a-f show the Medical Examinar must be notified at MD 1 Yes 2 No Worcester Berlin Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code **II323 Worcester Highway** 21811 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Thou If Yes, Give WW II Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Humanitarian Arts Patron 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lightly or other traumatic event 900g. Be Harold Finley Porter Elsie Banta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Sanz 187 Gallup Rd., Princeton, New Jersey 08540 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State Scott Family Cemetery 3-16-04 4 □Donation 5 □Other (Specify) Berlin, Md. 22. Name and Address of Facility 21. Signature of Fundal Service Licenses The Burbage Funeral Home 108 William St., Berlin, Md. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cases Approximate Interval Between Onset and Death hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Immediate Cause (Final disease or condition resulting in death) tas **Physician** tartic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ulmonar burial-transit Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) O 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of eause of death?

1 Yes 2 No 2 ☑ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 28c. Injury at Work? 27. Manne Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Matural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funerel Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 13/04 D53612 ML 30. Mame and address of person who completed cause of death (Item 23a) (Type, Print) Horca K Barer MD 9733 Healt 31. Date filed (Month State Registrar

Sutton, Anna Wae

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Division of Vital Records, P.O. Box 68760,	the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death.	the Funeral Director: After this certificate has been signed by the attending physician and
Division of Vita	the Hospital or Attending Physician: nin 24 hours after death.	the Funeral Director: After this certifical

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ledio amir		4a. Fecility Name (If no		e street and number)	Hasn	4b. City, Town.	or Location of Dea	th	4c. Co	ounty of De	ath
al or		5. Social Security Numb 221-16-0552		ex 7. Ag □ M 2∏ F	ie (in yrs. iast b	irthday) If Under 1 Year Yrs. Months Days			h y, Yea <i>r)</i> Q25	9. Bi	irthplece (Stete or Fo. Fountry) -aware
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once.		1 ☑ Burial 2 □ Ci 4 □ Donation 5 □	remation 3 Other (Specify			f Disposition (Name of ry, crematory or other pla Sbury Cemete					Town, State
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an al		23a. Part1. Enter the shock, or heart fai Immediate Cause (Fina disease or condition resulting in death)	llure. List only	olications that caused one cause on each lin	the death. Do	not enter the mode of dyn	ng, such as cardia	c or respiratory arr	est,		Approximate Interval Betwee Onset and Deat
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ייני מוסטינין אישט א פון אייני מוסטינין הם מפרפטיופן ווא חמושיוו מוצון אייני מוסטינין אייני מוסטינין אייני מוסטינין אייני מוסטינין איינין	To Be Completed by Physician/Medical	Sequentially list condition any, leading to immediate cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mon 1 Yes 2 No 9 Unknown Part II. Other significan END ST 25. Was case referred to examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide	gnant thts? It conditions comedical Pending investigation Could not be determined Certifying Phymedical Examined	b. Due to (or as a d. Due to (or as a d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown ontributing to death but REN Month, Day 28e. Place of Injunduilding, etc.	a consequence a consequence a consequence of pregnancy 2 Fetal death time of death ut not resulting in A L The consequence 2 Fetal death time of death at not resulting in A L The consequence a consequence 2 Fetal death time of death at not resulting in A L The consequence a consequence A L The consequence a consequence The consequence a consequence a consequence The consequence a consequence The consequence a consequence The consequenc	of): 3 Ectopic pregnancy 5 Other (specify) 1 the underlying cause given by the underlyin	26. Place of Dealer: 4 Nursing H y at k? Yes 2 No	24a. Was ar autops: 24a. Was ar autops: 24a. Was ar autops: 24b. Check only one 28d. Describe ho 28f. Location (Str. City or Town, 3 and due to the carried at the time, da	pacco use constant and pacco use constant and	Month ontribute to 3 Pr b. Were au prior to death? 1 Yes Other (Specurred manner as i.e., and due	livery Day Year the cause of death robably 4 Wunkn utopsy findings avail completion of cause 2 No cify)
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical	Sequentially list condition any, leading to immediate. Enter Underlyin Cause, Enter Underlyin that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mon 1 Yes 2 No 9 Unknown Part II. Other significan 25. Was case referred to examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide 29a. Certifier 1 2 (Check only one)	gnant thts? It conditions comedical Pending investigation Could not be determined Certifying Phymedical Examined	b. Due to (or as a d. Due to (or as a d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown ontributing to death but REN Month, Day 28e. Place of Injunduilding, etc.	a consequence a consequence of pregnancy 2 Fetal death time of death at not resulting in A L The second of the se	of): 3 Ectopic pregnancy 5 Other (specify) 1 the underlying cause given by the underlyin	26. Place of Dealer: 4 Nursing H	24a. Was ar autops: perform 1 Yes 2 ath (Check only one 5 Reside 28d. Describe ho 28f. Location (Str. City or Town, and due to the carred at the time, da	pacco use constant and pacco use constant and	Month ontribute to 3 Pr b. Were au prior to death? 1 Yes Other (Specurred manner as i.e., and due	ivery Day Year the cause of death robably 4 Munkn utopsy findings avail completion of cause 2 No city) ural Route Number, to the cause(s) h. Day, Year)

а	mend it	em	1- For State Registrar#10b, perfh,	State of Marylan	d / Department of Heal Certificate of Dea	ath	ene g. No. 2004 10456
	Physici /Medio Examir	cal	42 Facility Name (If not institution, give	HA WAR	O SPEARMAI	1 CORDANY	Day Year 29 2004 13:00 M 4c. County of Death
	Funeral Director		FENINSULA KEGI 5. Social Security Number 212-40-9004 Usual Residence of Decedent	ONAL MEdical 7. Age (In yrs.	Ast birthday) Ast birthday Ast birthd		Year) - 40 9. Birthplace (State or Foreign Country) MD
	with the Maryland is or 28e-f show	irector	10a. State 10b. County H MD 10e. Street and Number	ع طرحات	y, Town or Location oge wood 101. Zip Code	10	10d. Inside City Limits 1 ÆYes 2 □ No g. Citizen of What Country?
6:14/4 9004	death	y Funeral Director	1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 XYes 2 ☐ No If Yes, Give		c Origin? (Specify Yes or No- xican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
240- 1215-003	be filed within 72 hours after tal Hygiene. d other then "natural; or Ite event, the Medical Examine	Completed by	15. Decedent's Edu (Specify only highest grad	Year or Dates: cation e completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) SECYET		6b. Kind of Business/Industry Department of
Spen 215 Maryland 2	should be filed and Mental Hygi marked other matic event, I	To Be Co	17. Father's Name (First, Middle, Last) WAHER B. 1. 19a. Informant's Name/Relationship (Ty	Jyrs Uard		Mother's Name (First, Middle, M	aiden Sumame) : Les
Baltimore, Ma	ges 1 and 2 s t of Health ar if item 27 is or other treu		KENT Ward 20a. Method of Disposition 128 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. P	805 Sailbeat C lace of Disposition (Name of emetery, crematory or other place)	Edge wood Date 2	
Baltir	permit. Pac Department Importent: any injury once.		21. Signature of Funeral Service Licens 23a. Rant/ Enter the disease, or complete	cations that caused the death	30439 Hamp	Ward Funeral	Home CESS Anne UD 21853
8760,	Physician /Medical Examiner step physician and physician and step physician and step physician and step physician and physician	dicai Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last	Due to (or as a consequence of the consequence of t	Websut	erebral le	Interval Between Onset and early onset and ear
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
ords, P	w requires that been signed b should be deta	Completed by Pt	Part II. Other significant conditions con	ntributing to death but not results	ulting in the underlying cause given in P	Part I. 23e. Did toba	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
ital Rec	sicien: The law certificate has t rector, page 2 s	0	25. Was case referred to medical		26. F	24a. Was an autopsy performe 1 Yes 2 Place of Death Check online	
Division of Vital Records,	ding Phys I. After this funeral dir	ication; To B	27. Manner of ath 11 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury at Work? M 1 \(\text{Yes} \)		injury occurred
Divi	Hospitel or 24 hours afte Funerel Dir tely filled in 8	Medical Certification;	4 Homicide determined 29a. Certifier 1 Certifying Physics	building, etc. (Specify	me, farm, street, factory, office) wledge, death occurred at the time, dat ion and/or investigation, in my opinion,	City or Town,	Sa(s) and manner as stated
•	To the within 2 To the comple	Med	29b. Signature and title/bf certifier	12	ا ا ب	99c	Date signed (Month, Day, Year)
	Sta Registr	-	31. Date filed (Month, Day, Year)	mpleted cause of death (Item 32. Registrar's Signat	OD RIVERSICLE	In SALIK	sury, MD 71801

			1 - For State Registrar	State of Maryland	/ Departn		ealth and	F	giene leg. No. 2	004	1045
	Physic	an	Decedent's Name (First, Middle, Last) Carol	Joyce		Seaqui	at.	2. Date of Dea Month	ith Day	Year 3. 7	ime of Death
	/Medi		4a. Fecility Name (If not institution, give		46		Location of De	March 3,	2004 4c. County		:22A M
1	Examir	ner	5805 Arbroath Dri			Clinton		am		ce Georg	e's
	Funeral		Social Security Number 6. Sex			Inder 1 Year	If Under 24 H				State or Foreign
Ш	Director		517-26-1565	M 2♥F 76	Yrs. Moi	nths Days	Hours Mi	May 17		MN	
	pug w		Usual Residence of Decedent 10a. State 10b. County	10c City T	own or Location	2				10d In	side City Limits
	e Maryli ia-f sho liffed a	ctor	Maryland Prince Ge			linton					Yes 27 No
	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heath and Mental Hygiene. If item 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	10e. Street and Number 5805 Arbroath Dri	ve	10	f. Zip Code 2073	5		U.S.A	What Country?	
	death	nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was [Decedent of Hi	spanic Origin?	(Specify Yes or No- erto Rican, etc.)		ce - American Ind	ian,
36	or its	y Fu	1 Never Married 2 Married	1 ☐ Yes 21 No If Yes, Give		,specny Cubai es 2√D No	Specify:	erro Hican, etc.)	Specif	ck, White, etc.	
Ö	hours tural	q p	3 AWidowed 4 □ Divorced	Year or Dates:						willte	
7	in 72	Completed	15. Decedent's Edu (Specify only highest grade	completed)	6a. Decedent's (Give kind of life. DO No	Osual Occupa of work done d OT use retired;	luring most of w	orking	16b. Kind of B	usiness/Industry	
212	i with	шo	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	Artist	,			Solf-F	Employed	
פ	e filec othe vent,	Bec	17. Father's Name (First, Middle, Last)		111 0100		18. Mother's N	ame (First, Middle,			
/lar	should be filed with and Mental Hygiene. is marked other ther sumatic event, the M	ToE	Marcus Anderson				Lorra	ine 01s	on		
Maryland 21215-0036	2 sho and I is me		19a. Informant's Name/Relationship (Ty)					Rural Route Number			
	1 and Health em 27		Kristine Easley		-	-		ve Clinto			
Baltimore,	permit. Pages 1 and Department of Health mportant: If Item 27 Iny injury or other tr		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R	cemi	e of Disposition etery, crematory	or other place	Mar	ch 11,200	20c. Location -	City or Town, St	ate
Him	it. Pa rtmer rtant njury		*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		igton Na	itional	Cemete	ry Lee Func	Arling	ton, VA	
Bal	permi Depa Impo eny i		21. Signatura di Funerai Service License	2 V- man 257	6633	BOLd A	s of Facility lexandr	ia Ferry	RoadCli	nton, M	20735
#	Physician /Medical Examiner	ıer	23a Part. Enter the disease, or complishook, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Pneumonia Due to (or as a consequen Acute Mye Due to (or as a consequen	ce of):		j, such as cardi	ac or respiratory arr	est,	Interv Onse	oximate al Between t and Death Days
68760,	icate be executed physician and s the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	ce of):						
.O. Box	at the death certifica by the attending ph tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 13 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3 ☐ Ector	pic pregnancy or (specify)	- 1-1000		23d. Dai Mo	te of delivery nth Day	Year
ds, P	as this gned se de	by	Part II. Other significant conditions con	tributing to death but not resultin	g in the underly	ing cause give	n in Part I.	23e. Did tol	_	ribute to the caus	
Sor	w require been si should t	ete						-			
Il Records,		Completed						24a. Was a autops perform	y ned?	Were autopsy find prior to completion death? □ Yes 2□ No	n of cause of
Vital	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?					ath Check on on	9)		
of	Phys this al dii	1	1 Yes 2 No			DOA Other	4 Iduising	Home 5 Reside			
G	De He	ion	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28l	b. Time of Injury M	28c. Injury Work	at ? es 2 □ No	28d. Describe ho	w injury occurr	ed	
Division	ial or Attending s after death. I Diractor: After on by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)				28f. Location (St City or Town	reet and Numb , State)	er or Rural Route	Number,
	Hospit 4 hour Funera ely fille	Medicai C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my knowled er: On the basis of examination and manner stated.	dge, death occu and/or investiga	rred at the time ation, in my opi	e, date and place inion, death occ	e, and due to the ca urred at the time, da	use(s) and ma ite and place, a	nner as stated. and due to the ca	use(s)
	To the vithin 2 To the complet	Σ	29b. Signature and title of certifier	\$ 0/-		29c. License	number	2	d. Date signed	Month, Day, Ye	ear)
				AN		D4647	78		March l	1, 2004	
1	811		30. Name and address of person who con Suresh Patel MD	npleted cause of death (Item 23 7501 Surratts		307 Cli	nton. M	Maryland 3	20735		
	Sta		31. Date filed (Month, Day, Year)	32. Régistrar's Signature	x spe			:= <u>) </u>			
	Registi	ar	MAND 1 2. 21	HILL AND SELECTION							

		1 - For State RegistrarAMEND #26 PER PR		•	•		lealth and M Death		Reg. No	0001	10458
Dharaisi		1. Decedent's Name (First, Middle, Last)						2. Date of D Month	eath Da	y Yeer	3. Time of Death
Physicia /Medic		Yvonne Lorraine S	Swenton					MARCH	11	2004	7:47am M
Examin	er	4a. Facility Name (If not institution, give st					r Location of Death		4c.	. County of Deet	
		CIVISTA MEDICAL 5. Social Security Number 6. Sex		(In yrs. last birthe		PLA'	T'A	8 Date of B	irth	CHARLI	t S hplece (State or Foreign
neral ector			M 2DXE	67 Yr	Month		Hours Min.	8. Dale of B (Month, D July 2	22, Year)	.936 Con	necticut
E OA		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
a notified at	Funeral Director	Maryland Charles 10e. Street and Number		Wald		Zip Code			10g. Cit	izen of What Co	1 ☐ Yes XX No untry?
	Dia	8520 Bensville Road	d			20603	3-4053			USA	
	ner	11. Marital Status	2. Was Decedent I Armed Forces?	Ever in U.S.	13. Was Dec	cedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White	
	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🕅 N If Yes, Give Year or Dates:			2 X No	Specify:			Specify: Wh	ite
	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(9	ecedent's U: Give kind of ife. DO NOT	sual Occup work done	eation during most of world)	king	16b. K	ind of Business/	Industry
	omp	Elementary/Secondary (0-12)	College (1-4or 5	+)		anage				Grocery	
event, the Medical	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nam				
	ToE	Harold Arthur Duffy	y, Sr.				Margare	t Este	lle R	leed	
traum		19a. Informant's Name/Relationship (Type Thadeus J. Swenton			_		and Number or Rule e Road, W				
		20a. Method of Disposition		20b. Place of D	-			Date		ocation - City or	
1		1 ☐ Burial 2 🕅 Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)		Huntt C			3-12-	04	Wald	lorf, MD	
eny injury or other traumatic even once.		21. Signature of Funeral Service License	• M00053	Н	untt l	Funera	ss of Facility a 1 Home				
		23a. Pert1. Enter the disease, or complic	ations that caused	the death. Do no			156, Wald			04	Approximate Interval Between
cian dical lice as the printing street in the	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Equantially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a Due to (or as a	a consequence of) a consequence of) a consequence of)	TRA	ACT	1 N F E	CTIO	~		Onset and Death
	Physician/Medic	IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1 ☐ Yes 2 W No 9 ☐ Unknown	Bc. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐Ectopic 5 ☐ Other		1			23d. Date of deli Month	very Day Year
I be detached	by	Part II. Other significant conditions conf	tributing to death but			g cause giv	en in Part I.		1.00		the cause of death?
should	etec									245	6-4
page 2	Completed							24a. Was auto perf 1 ☐ Yes		prior to death?	topsy findings available completion of cause of
	Be	25. Was case referred to medical examiner?					26. Place of Dear	th (Check only			
rai director,	ို	1 ☐ Yes 2 No Ho 27. Manner of Death	ospital: 1 Inpatie				4 🗆 14u13i119 Ti	ome 5 Res		6 Other (Spec	city) AN IFO WAL CENTER
e funer	ation	1 Natural 5 ☐ Pending investigation	28a. Date of fnjur (Month, Day	Yeer) Inju		28c. Injun Wor 1 🗆	k? Yes 2 □No			, 000100	
d in by tr	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, eld	ury - Al home, farm c. (Specify)	n, street, fact	tory, office		28f. Location City or To	(Street an own, State	id Number or Ru i)	ral Route Number,
eteły fille	ledical (29a. Certifier (Check only one)	ician. To the basis of er: On the basis of and manner sta	examination and/	aath occum or investigati	ed at the tir ion, in my o	ne, date and place, pinion, death occur	and due to the red at the time	cause(s) , date and	and manner as I place, and due	stated. to the cause(s)
To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier		. 1	- 1	29c. Licens	e number		29d. Dat	te signed (Monti	n, Day, Year)
		Denjamin R.				D-38	147		MAR	CH 11,	2004
		30. Name and Indress of person who con	moleted cause of di	eath (Item 23a) (Tr	ype, Print)						
5			ENTAL MI)FFTC	E ROAD	WAI.DOR	FM	D 2060	2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2 Date of Death 1 Decedent's Name (First, Middle, Last) **Physician** 0600 10 2004 March 4nTwine /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Cambridge

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dorchester Genera Dorchester Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1**12**M 2□F 218-90-292 Usual Residence of Decedent Yrs. APR: 116, 1963 Maryland Director of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 tes 2 No Director Dorchester 10g. Citizen of What Country? 10e. Street and Number Son Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces?
1 Pyes 2 No 178/198/1998 Amed Forces?
1 Pyes, Give Year or Dates: 1982 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 6 Specify: Black 1982 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cabinetry 12 marked other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Margaret -emuel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 502 Dobson St. Cambridge MD. 21613
ca of Disposition (Name of Date 200 Stion - City or Town, State Margaret Jones 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Pisposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 18/04 Church Creek, MD 21. Signature of Funeral Service Licensee

22. Name and Address of Favilty

22. Name and Address of Favilty

Henry Funeral Home, P. A.

23a. Party Enter the disease, or complications that caused the death

25 to Washington, such as cardiac or respiratory arrest,

Approximate

Immediate Cause (Final Immediate Cause (Final disease or condition resulting in death) Cinhodis Physician 1Ver /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Dinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 L No 24a. Was an autopsy performed? 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 □Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) ST, CAMBRIDGE 300 HURORA AFZAL NUHAMMAD 31. Date filed (Month, MAR 1 2

DHMH 17 Rev 1/2001

State Registrar

Smith

Antwine

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Mar 23, 2004 **Physician** 7:20 am Santmyire Richard /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Oldtown 17900 Parrot Eyes Lane If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (Stete or Foreign **Funeral** Mar 29, 1932 1 M 2 □ F MO 71 Director 217-28-0648 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at MD Allegany Oldtown 1 ☐ Yes 2 € No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō USA 21555 17900 Parrot Eyes Lane 23a death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: white þ 3 Widowed 4 Divorced natural', Korea Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Parrot Eyes Exotic Owner 12 other of Health and Mental Hygistam 27 is marked other other traumatic event, I 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Mary Ann Cowgill Santmyire Ernest L. Santmyire 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17900 Parrot Eyes Lane Oldtown MD 21555 19a. Informant's Name/Relationship (Type, Print) wife Elaine Santmyire 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Pages 1 Department of P Important: If its any injury or ot once. 1 Surial 2 Cremation 3 Removal from State 3/26/2004 MD Rocky Gap Veterans Cemetery Flintstone * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nam Sand Address Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition and Death Physician resulting in death) /Medical Due to (or as a con equence of): Examiner CIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence Examine Hospital or Attending Physician: The law requires that the death certificate be executed the attending physicien and hed for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical ası IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 2 No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No Certification: To 4 Nursing Home 5 Nesidence 6 □Other (Specify, 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the ! 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of ce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishop Walsh Drive Cumberland MD 31. Date filed Month. Day Year 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of	Marylan		artment of I		and Mental Hy	giene Reg. No. 200	4 10461
	Physici /Medic		1. Decedent's Name (First, Middle, Inez Elizabet)		bott [Travers	3		2. Date of De Month March	Day V	ear 8:15 p M
	Examir		4a. Facility Name (If not institution, Mallard Bay Care 5. Social Security Number	e Center		last birthday)	4b. City, Town, o	idge			chester
	Funeral Director		217-28-3285 Usual Residence of Decedent	1□M 2/X F	92	Yrs.	Months Days	Hours	Min. 8. Date of Bi (Month, Date of Bi (Month, Date of Bi	, 1911 I	Birthplace (State or Foreign County) Mary Land
	death with tha Maryland ims 23a or 28a-f show r inust be notified at	ector	Maryland Dorch	ester	10c. Cit	y, Town or Lo Car	mbridge				10d. Inside City Limits 1 May Yes 2 □ No
KS	sath with the same or 2	Funeral Director	10e. Street and Number 424 Willis Stre	eet	ast Ever in II	C 123	10f. Zip Code 216		pin2 (Specify Vec es No	10g. Citizen of Wha	tt Country? American Indian,
980	ba filed within 72 hours after death with tha Marylan ital Hygiena. ed other than "natural; or items 23e or 28e-f show ovent, the Medical Examinat must be notified at		11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☒ Divorced	Armed Force	es? No	i	was Decedent or r f Yes, specify Cub 1 ☐ Yes 2 No	Specify:	gin? (Specify Yes or No i, Puerto Rican, etc.)	Specify:	White, etc. White
Maryland 21215-0036	within 72 hc ena. than "natu he Medical	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire ato Skint	during mos d)	t of working	16b. Kind of Busin	
land 2	should ba filed within nd Mental Hygiena. marked other than '	To Be Co	17. Father's Name (First, Middle, La George Riley N					18. Mothe	r's Name <i>(First, Middl</i> e a E. Abbot	, Maiden Sumame)	-0
	permit. Pagas 1 and 2 should by Department of Health and Menta Important: If item 27 Is marked eny injury or other traumatic e gnce.		19a. Informant's Name/Relationship. Theodore R. Abb		Son	3198	Lakesvi	Lle Ro	or or Rural Route Numb	Creek, MD	21622
Baltimore,	t. Pagas 1 rtment of H rtant: If ite		20a. Method of Disposition 1. Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie	cify)	ate Sa	ndy Is	sition (<i>Name of</i> natory or other pla land Ceme s. Name and Addre	etery	3-9-2004	Robbins	, Maryland
Ba	permi Depa Impo eny is		Justle fixed	ad Sil	MUU sed the deat	CI CI 30 h. Do not ent	urran-Bro 08 High S er the mode of dyin	omwell St., (Funeral H Cambridge, Cardiac or respiratory a	ome, P.A. MD 21613	Approximate
	Physician /Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a	in line.	sclen			disease		Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	as a conseq	uence of):					= -
8760,	icate be exacuted physician and the burial-transit	icai Exar	that initiated events ' resulting in death) Last	c. Due to (or	as a conseq	uence of):					
P.O. Box 68	law raquires that the daath certificate be exacuted as been signad by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ∏ Feta ntattime of d	Ideath 3□	Ectopic pregnancy	·		23d. Date of Month	delivery Day Year
ecords, P.	quires that i on sign a d by uld be deta	by	Part II. Other significant condition	s contributing to deal	th but not res	ulting in the ur	nderlying cause gru	en in Part I.			te to the cause of death? Probably 4 Munknown
$\mathbf{\alpha}$	The law raquir ate has been si page 2 should	Completed							24a. Was autop perfo	rmed? deat	
on of Vital	ding Physician: The Ih. After this certificate ha	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of (Month,		ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 ⊠Nu y at k?			Specify)
Division	Il or Attending after death. Diractor: After d in by the fune	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of	Injury - At ho , etc. <i>(Specif</i>)	ome, farm, stre	M 1 □ eet, factory, office	Yes 2⊡t			r Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funerel Diractor: completely filled in by the	edical	(Check only 2 Medical Ex	caminer: On the basi and manne	s of examina r stated.	tion and/or inv	restigation, in my o	pinion, deat	d place, and due to the h occurred at the time,	date and place, and	due to the cause(s)
	To t withi To t	×	30. Name and address of person with the state of the stat	1 MD			29c. Licens	e number OSZL	59	29d. Date signed (M	onth, Day, Year)
			30. Name and address of person with the state of the stat	no completed cause	of death (Item	23a) (Type, 1	BUROR.	of 87	CAMBR.	104e ,1	10-21613
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			1 State of Maryland /	Department of Health and Certificate of Death	Mental Hygie		10462
Ţ	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Media	cal	John S. Thompson 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deal	March 11		12:30 💆
	Examir	ıer	701 Glenwood St. Apt. 608	Annapolis	ın	4c. County of Death	m.d.o.1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit			Anne Ar	UNGEL place (State or Foreign ptry)
	Director		219-30-6700 1\(\overline{A}\)M 2□F 70	Yrs. Month's Days Flours Mill.		933 Mary	
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	m or Location		1	Od. Inside City Limits
	Many Be-f ah	tor	Maryland Anne Arundel Annan	101is			1 ∰Yes 2 □ No
	after death with the Maryland or Herns 23a or 28a-f ahow mirer must be notified at	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
	s 23a		701 Glenwood St. Apt. 608	21401		USA	
_	fter de r ftem liner i	Funeral	11. Marital Status 11. Maried Status 12. Wa's Decedent Ever in U.S. Armed Forces? 12. ∑∑Ses 2 □ No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
22	ral', o	þ		1 ☐ Yes 2 🙀 No Specify:		Specify: Bl	ack
ה	be filed within 72 hours after death with the Marylan ital Hygiene. od other than "natural", or Hems 23a or 28a-f ahow event, The Medical Extenirer mark be notified at	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of wo	rking 16b	. Kind of Business/Ind	dustry
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la l	should be nd Mental marked o	To B	George S. Thompson	Margue	erite Swa	nn	
100	12 sho			D. Mailing Address (Street and Number or Ru			
ָ ט	1 and Healtl em 27		20a. Method of Disposition 20b. Place o	24 Highland Dr. And Disposition (Name of		Glen Bur: Location - City or To	
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a 00ce.		**DBurial 2 Cremation 3 Removal from State Chews	ury, crematory or other place) UM Church		1000000	0.000
2	permit. I Departm Importar Inny injui		21 Signature of Funeral Service Licenses	20 Alama and Address of English	T	wensvill	e, Md.
۵	89 5 8		Lavry S. Reese Moo 483	Wm. Reese & Sor	ns Mortua	ry, P.A.	Ω1
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	114 . 214	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ce heart faile	ne e		6 months
	Examiner		Due to (or as agonsequence	of):			
	n &	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):			
	icate be executed physicien and s the burial-transit	Examiner	trial lineated events				
000	be ex sicien burial	al E	resulting in death) Last Due to (or as a consequence	or):			
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	that the ed by detacl	Δ.	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I	23e. Did tobacc	o use contribute to the	e cause of death?
Ŝ	w requires that been signed to should be det	d by	Alcoholism	The second of th		2□No 3' X Proba	
5	aw rec s bee	piete	huhertension		24a. Was an	24b. Were autor	osy findings available
	sician: The law certificate has b irector, page 2 si	Completed	corman aftern di	isease	autopsy performed? 1 Yes 2 X	death?	npletion of cause of 2 No
	Attending Physician: The r death. ector: After this certificate hiby the funeral director, page	Be	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)		
5	Phys.	- To		itpatient 3 DOA Other: 4 Nursing H	ome 5 Residence 28d. Describe how in	6 ☐Other (Specify,)
5	nding I th. :: After s funer	ation		njury Work? M 1 Yes 2 No	20d. Describe flow in	July occurred	
	r Attender death rector:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, Sta		Route Number,
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier Certifying Physician: To the best of my knowledge (Check only one) Medical Examiner: On the basis of examination and manner stated.	 death occurred at the time, date and place d/or investigation, in my opinion, death occu 	, and due to the cause rred at the time, date a	(s) and manner as sta nd place, and due to	ited. the cause(s)
	Fo the within Fo the comple	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, D	
			I slower Clores	D4810	1 1	lorch 1	5,2004
			30. Name and address of person who completed cause of death (Item 23a) (D4810 (Type, Print) 2 Medical Pwy S	7 4 2 =	Λ	
	Sta	0	JONNA Cham DES MD 2007 31. Date filed (Month, Qay, Year) 32. Refistrar's Signature	2 medical twy	July 350	itmajos	5140/
	Star Registra		31. Date filed (Month, Day, Year) AR 1 5 2004 32. Refistrar's Signature	Small 1			

Registrar

State

BRYAN J. MCVERRY

MAR 0.9 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ANNE ARUNDEL MEDICAL CENTER

ANNA POLIS, MD

			1 - For State Registrar	State of Maryla		artment of F			200	L 101.61.
			Decedent's Name (First, Middle, Last)			Timouto of	Douth	2. Date of Death	3	3. Time of Death
	Physici		MARY EMILY TRA	ACY VANZE	INT			MARCH	Day Year	1 47 44
	/Medic Examir		4a. Facility Name (If not institution, give s		1. 4 1	4b. City, Town, o	r Location of Deat		4c. County of De	<u> </u>
			Chester River Mano	r		Chester	rtown		Kent	
	Funeral		Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	rear) (irthplace (State or Foreign Country)
éjs.	Director		218-20-5387 Usual Residence of Decedent	91	Yrs.			July 28	,1912 Ma	ryland
	land W		10a. State 10b. County	10c.	City, Town or Le	ocation		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
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	r 28a	rec	10e. Street and Number		NOCK 11a	10f. Zip Code		10	g. Citizen of What (Oountry?
	h with	O is	20988 Bayside Ave	•		21661			USA	,
	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or Rems 23a or 28a-f show int, I'ra Madical Examinat must be mailled at	by Funeral Director		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - Am	
9	or h	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐XNo If Yes, Give		1 ☐ Yes 2 ☐ ₹No	Specify:	o moan, etc.)	Black, Wh	
8	ural',	d b	3 □Widowed 4 □ Divorced	Year or Dates:						white
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12	within ene. then	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)			,	1	Wursing/He	ealth Care
<u>0</u>	Hygo other	Be C	17. Father's Name (First, Middle, Last)		Priva	te Care N	TOTAL	ne (First, Middle, M		
lan	Ald be Aenta rked tic ev	To B	James Tracv				Clara M	Mansfield	Moran	
ary	3.2 should be filed within 7 h and Mental Hygiene. 7 Is marked other then "Iraumatic event, Ira Med	-	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Maili	ng Address (Street		ıral Route Number,		Zip Code)
Σ	and 2 lealth m 27 I		Ruthann Vanzant Ker				de Ave. R	Rock Hall,	Md. 2166	51
Baltimore, Maryland 21215-0036	of H of H if its		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re		. Place of Dispo cemetery, crei	sition (Name of matory or other plac	(8)	Date 2	Oc. Location - City of	r Town, State
Ē	permit. Pages Department of I Important: If it any injury or o		`4 ☐Donation 5 ☐ Other (Specify)	We	sley Ch	apel Ceme	etery 3/	6/04 Ro	ock Hall,	MD
39	Departi Importi any inj once.		21. Signature of Funeral Service License	1115	22 F	2. Name and Addres	ss of Facility RC	oute #20 F	Rock_Hall	MD.21661 1 HOme PA
	9038Q		23a. Part1. Enter the disease, or complic	legelen						
4-3			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	ath. Do not ent	er the mode or dyin	ig, such as cardiad	or respiratory arres	61,	Approximate Interval Between Onset and Death
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39	ing ph	Med	IF FEMALE:							
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Record	w requir	Completed	B) A white Mi	The state of	(a) A	0. + 0	2	24a. Was an	24h More a	utanov findings available
Re	he faw e has age 2 :	ш	O in a culture	the soll		in in re	Lucyson	autopsy	ed2 death?	utopsy findings available completion of cause of
Vital		e C	25. Was case referred to medical	Mr. C. Han	upares	y	26 Place of Doc	th (Check only one	IVNo 1 ☐ Ye	s 2 No
		To B	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA Othe		ome 5 Residen	ce 6 Other (So	20(6)
Division of	ding Phys I. After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of			28d. Describe how		schy)
jo	ttendin death. stor: Afr	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Four)	injury		Yes 2 □ No			
<u>.</u>	after deatl Director: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	tural Route Number,
Ω	ital or rel D	Cer								
	Hosp 24 ho Fune fely fi	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Examin	icien: To the best of my k er: On the basis of exami	nowledge, death nation and/or inv	n occurred at the time restigation, in my op	ne, date and place, pinion, death occur	, and due to the cau rred at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the Hospital or At within 24 hours after or To the Funerel Directompletely filled in by	Med	29b. Signature and title of certifier	and manner stated.		29c. License			I. Date signed (Mon	
	F ≯ F 8		1111111	m		-	1313			
			30. Name and address of person who cor	mpleted cause of death //t	em 23a) (Type	Print)	. 210		3/5/04	
			KIN K. WUN	1, 415 W	ashing	ton Au	e., Ches	leitour	mo 2	1620
e i	Sta	te	31. Date filed (Month, Day, Year)	32. Regetrar's Sig	nature	1	- 4			
	Registr	ar	MAR 0 5 2	004 Malere	1. 1	annull s				

			For	State of M	aryland	d / Depa	artment	of Hea	alth and N	Mental Hy	giene	200	4 10465
			1 - State Registrar			Cer	tificate	of De	eath	F	Reg. No.		
	Physicia	an	1. Decedent's Name (First, Middle,							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Paul Dirk Vande				45 Cit. 7	Town orlo	cation of Death	March		2004 County of Deat	2:48 A
A	Examin	er	4a. Facility Name (If not institution,				•	apolis				ne Aru	
	Euporol		Anne Arundel Med			ast birthday)	If Under	1 Year If	Under 24 Hrs.	8. Date of Birt	h	9. Birt	hplace (State or Foreign
	Funeral Director		218-68-4499	1 ₩ M 2□ F	48	Yrs.	Months	Days H	lours Min.	March March	25,	1955 M	aryland
	P _		Usual Residence of Decedent		40- 07								
	show	_	10a. State 10b. County		,	, Town or Lo							10d. Inside City Limits 1. Yes 2 □ No
	28a-1	Director	Maryland Anne 10e. Street and Number	Arundel	Anı	napoli	S 10f, Zip	Code			10a Citi:	zen of What Co	.9
	with	급		rice Ant 13	2			1403			-	ced Sta	•
	16ath	Funeral	680 Americana Dr	12. Was Decedent	Ever in U.S	S. 13. V			inic Origin? (Sp	ecify Yes or No-		4. Race - Ame	rican Indian,
0	or iter		1 Never Married 2 Marrie	Armed Forces?						Rican, etc.)		Black, White	
2	rai', c	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□Yes 2	NO 5	Specify:			Specify: wh	ite
ה	72 h "natu dicul	Completed	15. Decedent's (Specify only highest			16a. Deced	kind of worl	k done durir	n ng most of worl	ing	16b. Kir	nd of Business/	Industry
V	within	du	Elementary/Secondary (0-12)	College (1-4or	5+)		incip	Court,			sci	nool	
7	be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene and other than "natural", or items 23s or 28s-f show event, the Medical Evanities finant be notified at		17. Father's Name (First, Middle, Li	5+		- pr	тистр		. Mother's Nam	e (First, Middle,			
land	ld be ental ked o	To Be	Dirk Vandenberg					1	Mary K.	Peagenl	nard	t	
	shou nd M mar		19a. Informant's Name/Relationshi	р (Туре, Print)		19b. Mailin	g Address			al Route Numbe			Tip Code)
Z Z	and 2 alth a 127 is 127 is		Mary J. Wolters	s/ sister					Street	. Cumber:	land	MD 215	02
e,	es 1 and 2 of Health fitem 27 i		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation		20b. PI	lace of Dispo emetery, cren	sition (Nam natory or oti	e of her place)		Date	20c. Lo	cation - City or	Town, State
Ĕ	Pag ment ant: i ury o		`4 □ Donation 5 □ Other (Spe		Ba					10, 20			
Бант	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menlart Hygiene. Importment of Health and Menlart Hygiene. In important if free 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examin or must be rectified at QDCs.		21. Signature of Funeral Service Li	icensee _	1-								al Home, Inc
_	40 7 8 Q	21 2	23a. Part1. Enter the disease, or o	FOMM	Dly.							napolis	, MD 21401
			shock, or heart failure. List o	nly one cause on each li	ne.	C C	er trie mode	or dying, s	don as cardiac	or respiratory ar	1031,		Interval Between Onset and Death
,	Physician /Medical		disease or condition resulting in death)	a		Jeps	15						days
	Examiner			Due to (or as	a 8	cvotiz	ina (ancre	atins				2 months
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as) '	1000					
	cuted od ransit	Examiner	Cause (Disease or injury that initiated events	c									
/og/	be executed Ician and burial-transil	Ex	resulting in death) Last	Due to (or as	a consequ	uence of):							
2	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical		d									
X OX	law requires that the death certificate as been signed by the attending phys. 2 should be detached for use as the	/Med	IF FEMALE:	23c. If yes, outcome	of pregna	ncv						3d. Date of del	ivane
X D D	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pre Other (spe					Month	Day Year
j.	the d ny the ached	ysl	1 Yes 2 No 9 Unknown	9□ Unknown									
 T	s that ned b e deta	by P	Part II. Other significant condition			ulting in the ur	nderlying ca	use given ir	n Part I.	23e. Did to	bacco u	se contribute to	the cause of death?
ğ	en sig	ed b	Intestina	1 hemorrha	ge					1 🗆 Y	es 2	No 3□Pr	obably 4 Unknown
သ	iaw re as be 2 sho	plet	Renal F	oilure						24a. Was autop	SY	24b. Were au	topsy findings available completion of cause of
ľ	The ate h page	Completed	Phenno	nia_						perfo	med? 2 No	death? 1 ☐ Yes	2□ No
7113	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othor		th (Check only o			
0	Physical dir	To.	1 Yes 2 No	1 M Inpati		ER/Outpatien 28b. Time of		^		ome 5 Resid			city)
	fing After fune	tlon	1 Natural 5 Pending 2 Accident investiga		y Year)	Injury	м	Sc. Injury at Work? 1 Yes	2 🗆 No		, ,		
DIVISION	Attending or death. ector: Afte by the fune	fica	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place of In	jury - At ho	me, farm, str	eet, factory,	office		28f. Location (S City or Tow			ral Route Number,
5	s afte	Certification:	4 Homicide determin	building, e	.с. (<i>Specn</i> y	′)				Only of Tow	ni, Siaie)		
	To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certific completely filled in by the funeral director,		(Check only 2 Medical E	Physician: To the best exeminer: On the basis of	of examinat								
	the h	Medical	one) 29b. Signature and title of certifier	and manner si	ated.		29c.	License nu	ımber		29d. Date	signed (Monti	n. Dev. Year)
	F 3 F 8			al Bech, M	D			D46				319/04	
7						23a) (Tvoe.	Print)_		^				
			30. Name and address of person w	ech, MD	2001	medica	al Poul	cway	Univa	polis, M.	D		
	Sta Registi		31. Date filed (Mortin, Day, 19ar)	32. Poist	rar's Signa	ture	Carle	,					

			1 - For State Registrar	State of Ma		l / Depa		t of H	ealth a	nd Mental		ne 200		
	Physici /Medi	cal	1. Decedent's Name (First, Middle, L Esther 4a. Fecility Name (If not institution, gi	atson			4b City	Town or	Location of	Mont Marc	of Death	Dey Yes 2004 4c. County of D	3:50 P M	
	Examir Funeral Director	ier	Chestertown Nu 5. Social Security Number 6.	rsing & Reb		Ctr. st birthday) Yrs.	<u>.</u>	neste	ertown If Under 2 Hours	1	of Birth	Kent # Birth # Dey, Yeer) 28, 1911 W. Vir		
	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Oppartment of Health and Mental Hygiene. Oppartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any jinury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Usuel Residence of Decedent 10a. State 10b. County MD Ke 10e. Street and Number 415 Morgnec Road 11. Marital Status	12. Was Decedent I	Ch	Town or Lo	town 101. Zip	216		in? (Specify Yes Puerto Rican, etc	10g.	Citizen of What	10d. Inside City Limits 1 Yes 2 No Country? A merican Indian,	
21215-0036	ed within 72 hours aft giene. er than "natural", or it, t, the Medical Examit,	Completed by F	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest g, Elementary/Secondary (0-12)	College (1-4or 5		16a. Deced (Give life. I	kind of wo	al Occupa rk done d se retired;	ntion luring most	gist	Ве	Specify: Kind of Busine Pauty Sa	•	
Maryland	2 should be fite and Mental Hy le marked oth aumatic event	To Be	17. Father's Name (First, Middle, Las Richard Gibson 19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a	Ros	's Name (First, M SA Humphi or Rural Route N	cey		a, Zip Coda)	
Baltimore, M	permit Pages 1 and 2 Department of Health Important: If Item 27 I any in ury or other tra		Doris L. Gabor/ 20a. Method of Disposition 1 Burial 2 Cremation 3 (4 Donation 5 Other (Special Signature of Funeral Service Lice	□Removal from State	cer	celawn	Mem. Name an	Par Par d Addres	k 3	oein & Ne	Nev	v Castle	or Town, Stete e, Delaware Home, P.A.	
760,	Physician /Medical Examiner	ical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset Archive	
P.O. Box 68	Attending Physicien: The law requires that the death certifica croadal. strobath. strotath. stropping the certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of □Live birth 4□ Pregnant at 9□ Unknown	2 ☐ Fetal d	leath 3	Ectopic pr					23d. Date of o	delivery Day Year	
Vital Records, P	aw requires that is been signed b 2 should be deta	Completed by Ph	Pan II. Other significent conditions And we's			-			n in Part I.	24a.	1 ☐ Yes Was an	24b. Were	to the cause of death? Probably 4 Unknown autopsy findings available	
	Physicien: The law this certificate has t al director, page 2 s	To Be Com	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatier	nt 2□E	R/Outpatien	t 3 🗆 DO	Othe		1 Y	on one	death	es 20 No	
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	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in I	edical	29a. Certifier (Check only one) Certifying P	hysician: To the best of miner: On the basis of and manner sta	examinatio	edge, death n and/or inv	occurred a restigation,	at the time in my opi	e, date and inion, death	place, and due to occurred at the t	the cause ime, date a	(s) and manner nd place, and d	as stated. ue to the cause(s)	
	To the within 2 To the complete	M	29b. Signature and title of centiler 30. Name and address of person who	- M)	(3a) (Tuna 1		License	number		29d. [Date signed (Mo	nth, Dey, Year)	
87	Sta Registr		Dr. Frederick D		, 660	2 Chu	rch F	li 11	Rd.,	Chestert	own,	MD 2162	0	

			1 = For State Registrar		State of Ma	ırylan	d / Depa <i>Cei</i>	artme <i>tifica</i>	nt of He ete of D	ealth and Death	Me	ntal Hy	giene Reg. No	201) 4	104	67
	Physic	an	Decedent's Name (First)	, Middle, Las	(1)							Date of De Month	eath Da	ly .	(ear	3. Time of E	
	/Medi	cal	Lennie 4a. Fecility Name (If not in	stitution nive	W.		White,			Location of Dea		-eb	40	27,0 . County of	Death	072	5 M
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	Funeral		5. Social Security Number	6. S		(In yrs. I	last birthday)	If Und	er 1 Year	If Under 24 Hr Hours Mir		Date of Bi (Month, D.				ace (State or	Foreign
	Director		212-26-6641 Usual Residence of Dece		A W 2 -	75	Yrs.)2/04/	1929	9]	Mary	land	
	yland			County		10c. City	y, Town or Lo	cation						-	10	d. Inside City	
	8a-fa	ctor		omerse	t	C	risfie									1 Yes	2 No
	with the a or 2	Die	10e. Street and Number					10f. 2	ip Code	7			10g. Ci	tizen of Wh		ry?	
	ms 23	Funeral Director	10 North F	irst S	12. Was Decedent I Armed Forces?	ever in U.	S. 13. V	Vas Dec	2181 edent of His	spanic Origin? (n, Mexican, Pue	Specif	y Yes or N	0-	US.	America		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow amy injury or other traumatic avant, the Medical Examinational Examination of the process.	by Fur	1 Never Married 2	,	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	lo			2 No	Specify:	irto Hic	an, etc.)		Black, Specify:	White, e	_{tc.} ite	
21215-0036	72 ho	Completed	15. Do	ecedent's Ed	lucation de completed)		(Give	kind of v	sual Occupa vork done di	uring most of wi	orking		16b. K	(ind of Busi			
121	within ane. than	Idm	Elementary/Secondary		College (1-4or 5	+)	life. L	DO NOT	use retired)					0	C 1		
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/lan	uld be Wental krked krked	To B	Benjamin W	hite						Louise	St	ein					
Maryland	2 sho		19a, Informant's Name/Re		•			_		nd Number or F							
e,	1 and Health am 27 sthar t		Janis B. W		ite	20b. P	lace of Dispo	sition /N	ame of	Street	Date			Md ocation - C		_	
ПO	Pages ent of nt: If if		1 Burial 2 Cren	nation 3 [Removal from State		emetery, cren			" ry 03/	01.	2004	Conta	efic1.	ı M	- mr. 1 on	a
Baltimore,	rmit. I spartm sports y inju	/	21. Signature of Funeral S	Service Licen	See .	ASU	22 H	Name	and Address	s of Facility eral Ho:	me UI/	2004	CLI	strer	فلال وال	aryran	<u>u</u>
00	80E 2 9		KINEDO X	VIKIN	an Is M	0029	5 1	1673	Some	rset Av	Α.,	Prin	cess	Anne	, ME	21853	3
			23a. Part 1. Enter the dise shock, or heart failur Immediate Cause (Final	e. List only	one cause on each lin	the death e.	n. Do not ent	er the m	ode of dying	, such as cardia	ac or re	spiratory a	irrest,			Approximate Interval Betwo Onset and De	een
7	Physician /Medical	V	disease or condition resulting in death)	-	a L // Due to (or as		CA	NC	ER								
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P.O.	that the de ned by the a detached f	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unknown												
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ooa	e faw re has bee je 2 sho	Completed									Ì	24a. Was		24b. We	re autop	sy findings av	vailable
E B	The ate	Соп										perfo	rmed? 2/X No	dea	ath?	No No	
Vita	ysician: Th is certificate director, pag	Be c	25. Was case referred to examiner? 1 ☐ Yes 2 🛣 No	medica!	Hospital: 1 ☐ Inpatie		50 /0 4= 44=		Othe	26. Place of De				4.000			
o	두 두 등	n: To	27. Manner of Death		28a. Date of Injur (Month, Day	v	ER/Outpatien 28b. Time of Injury	t 3 🗆 [28c. Injury Work	4 Nursing		. Describe					
sior	Attending F death. ctor: After y the funer	atlo	2 Accident	Pending investigation		70417	milary	М		es 2 □ No							
Division	s after du s after de al Direct ed in by t	Certific	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of Injubulding, etc	iry - At ho . <i>(Specif</i> y	ome, farm, stre	eet, facto	ory, office		281.	Location (City or To	Street an wn, State	nd Number 9)	or Rurai	Route Numbi	9 <i>r</i> ,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Certification:	29a. Certifier 12 C (Check only 2 M one)	ertifying Ph edical Exan	ysician: To the best on hiner: On the basis of and manner sta	examinat	wledge, death tion and/or inv	occurre	d at the time on, in my opi	e, date and place inion, death occ	e, and urred	due to the at the time,	cause(s)	end mann d place, and	er as sta	ted. he cause(s)	
	To the To the Comp	ž	29b. Signature and title of	certifier	7				9c. License		0	-7	29d. Da	te signed (Month, D	ay, Year)	
									POC	3476	3	/	1/6	ira	-1	007	
			30. Name and address of JCE In:			ath (Item	23a) (Type,	erint) WV	Cris	field	M	D					
	Sta		31. Date filed (Month, Day	, Year)	32. Registra	r's Signa	ture	-	. 4	5476 field	,						
	Regist	rar	M	IAK ():	2004	Acres a	K	Ana									

				4 For		aryland / De	partment	of Health and				10468
				1 - State Registrar		C	ertificate	of Death		Reg. No.		
	T.	Physici	an	Decedent's Name (First, Middle, L			. / / / !		2. Date of De Month	Day,	Year	3. Time of Death
		/Medic	cal					GTON JR		-	2004	05=50 M
		Examir	ier	4a. Facility Name (If not institution, g				own, or Location of Deat			nty of Deeth	1.0
	47	Funeval	7.6	5. Social Security Number 6.		e (In yrs. last birthda		Year If Under 24 Hrs				
	و مار	Funeral Director		220-07-8125	X □M 2□F	83 Yrs.	Months	Days Hours Min.	B. Date of Bir (Month, Da Jan 25	1921	Mary	place (State or Foreign ortry) yland
		D.		Usual Residence of Decedent								
		iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Exacting must be notified at	ctor	Maryland Harfo	ord	10c. City, Town or	Joppa				1	1 ☐ Yes 2 ☑ No
0		th with th	Funeral Director	10e. Street and Number 407 Dembytown I	Road		10f. Žip C	21085		10g. Citizen	of What Cour	ntry?
3		ems ems	ner	11, Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1:	3. Was Deceder	nt of Hispanic Origin? (S y Cuban, Mexican, Puerl	pecify Yes or No)- 14. F	Race - Americ Black, White,	can Indian,
5	98	or it	Y.F.	1 Never Married 2 Marned	1 XYes 2 1	40		XNo Specify:	o moun, oto.,		cify: Bla	
0	00	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	1944-46				1		
	5	. 30	Completed	15. Decedent's (Specify only highest g	Education rade completed)	16a. Dec	cedent's Usual (ve kind of work	Occupation done during most of wor retired)	rking	16b. Kind of	Business/In	dustry
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	d 2	filed Hygi Sther		17. Father's Name (First, Middle, La:	st)		Cabcoar		ne (First, Middle			OI2
	an	ld be ental ked c	To Be	Roy McKinley Was	shington. S	r.		Helen T	homas			
4	ary	shound M	-	19a. Informant's Name/Relationship			iling Address (S	Street and Number or Ru		er, City or Tov	vn, State, Zip	Code)
0)	Ž	alth a alth a 27 la		Patience Washingt	on / wife	407	Dembyto	own Road, J	oppa, MI	21085		
70/8/64	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygene. Important: if item 27 is marked other than any injury or other traumatic event, ILE M. ODGe.		20a. Method of Disposition		20b. Place of Dis	position (Name rematory or other	of er place)	Date	20c. Locatio	n - City or To	own, State
3	E	Page nent ant: H		1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec	::fy)			Grds. 3/	12/04	Middl	e Rive	er, MD
,	a	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Lic	ensee		22. Name and	Address of Facility	al Uomo	D 7		
	_	89 = 29		augun	cott		552 Le	Address of Facility Scott Funera Ewis Street	, Havre	de Gra	ce, MD	21078
3112 5	760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as			F FAILUR		DISEA	100	Onset and Death
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	P.0	that ti ed by detac		Part II. Other significant conditions	contributing to death be	ut not resulting in the	underlying cau:	se given in Part I.	23e. Did t	obacco use co	ontribute to th	e cause of death?
	ds,	uires sign ld be	d by	ASCU		-	, ,	•	10	Yes 2 □ No	3 🔁 Prob	ably 4 □Unknown
5	Records,	w requires that been signed b should be deta	Completed						24a. Was	an 241	Ware autor	osy findings available
20,	Re	he la e has	mc	5/3 <					autor perfo	med?	prior to con death?	npletion of cause of
W.	Vital	an: T	Ö	25. Was case referred to medical				26. Place of Dea	th (Check only o		1 🗆 Yes	2 INCNo
8		ysicil s cer direct	O B	examiner? 1√2 Yes 2 □ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpati	ent 3 DOA	0.4	ome 5 ☐ Resid		ther (Specify	,
45	٥٥	ig Ph ter thi	n: T	27. Manner of Death	28a. Date of Injur (Month, Day		of 28c	. Injury at Work?	28d. Describe I			,
Ω.	<u>io</u>	andin ath. or: All	atlo	1 Accident 5 Pending 2 Accident investigati	on	, roasy mijory	М	1 ☐ Yes 2 ☐ No				
Shi	Division	al or Atte s after de il Directo id in by ti	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home, farm, : c. (Specify)	street, factory, o	office	28f. Location (S City or Tox	Street and Nut vn. State)	n <i>ber or Rur</i> a	l Route Number,
Washington		To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has complately filled in by the funeral director, page 2	Medical C	29a. Certifier 1 ☐ Certifying F (Check only one) 2 ★ Medical Ext	Physician: To the best of iminer: On the basis of and manner sta	examination and/or	ath occurred at investigation, in	the time, date and place my opinion, death occu	, and due to the rred at the time,	cause(s) and date and place	manner as sta e, and due to	ated. the cause(s)
		To th within To th comp	Me	29b. Signature and title of certifier	>			icense number		29d. Date sign	ned (Month, L	Dey, Year)
				Garrisht	who	M.D.		021809		MAZC	H &	2004
		2+1VA		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	e. Print)					
		OLIVI.		1 1 1 0 1 0	102		20	Timonium	MD.	2153		
		Sta Registr		MAR 1 0 2004	32. Registra	ar's Signature						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Lest) 3. Time of Death Month Dev Year Physician 2004 Robert L. Wood /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner PRSDE If Under 24 Hrs 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Dey, Year 7. Age (In yrs. last birthdey) 6. Sex Birthplace (Stete or Foreign Country) **Funeral** Days Hours Months 1₩ M 2□ F 160-24-8261 74 1929 Director 9 Pennsylvania Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. Stete Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Directo Philadelphia Philadelphia Pennsylvania 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 936 East Durard Road 19150 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Maritel Status 1 XYes 2 No If Yes, Give 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specity: Specify: Completed by **Black** 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Philadelphia Fire Dept. Elementery/Secondary (0-12) College (1-4or 5+) Philadelphia, PA Fire Paramedic Twelve Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) permit. Peges 1 end 2 should be flik Depertment of Health end Menlei Hy Important: If Nem 27 ie marked other eny Injury or other traumatic event John Alfonso Wood Eleanor Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 609 Silver Bell Drive, Edgewood, Maryland 21040 Andrea Smith (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/19/04 Collingdale, Pennsylvania Eden Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service License 21903-0766 X Perryville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner to (or as a consequence of Physician/Medicai Examiner roels Permony Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): end Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown new dideans þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 ∐ Yes 2 DNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No edicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Physician: The lew requires thet the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital

Baltimore, Maryland 21215-0020

Hygiene.

: After this certifice a funeral director, p s efter deb... el Director: Afte filled in by within 24 hours e To the Funerel C

lot IVA

State

Registrar

Alles 31. Dete filed (Month, Dey, Yeer) MAR 1 6 2004

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

30. Name end address of person who completed cause of death (Item 23a) (Type, Print lue W

and manner steted.

32. Registrar's Signature

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Yeer)

		For State Registrar	State of Maryland		tificate of L		2. Date of De	Reg. No. 2		1047
Physicia	an	1. Decedent's Name (First, Middle, Last) Harold C. Was	rdor				March	10,20		7:39 a M
/Medic	al -	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea			inty of Death	
Examin	er	Morningside Ho			Waldon			Cl	harles	
Funeral Director		5. Social Security Number 6. Sep. 216-44-6691		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth ay, Year) 1910	9. Birthplace Country) Mary	e (State or Foreig Land
2 *	}	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d.	Inside City Limits
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geath with the Malyand ms 23s or 28s-f show finals be politied at	Directo	10e. Street and Number			10f. Zip Code			•	of What Country	?
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tal Hygiene. d other then "natural", or liems 23a or event, the Medical Exam and multi bas	by Funeral	11. Marital Status 1 □ Never Married 2 ☼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 【【No		Specify Yes or Norto Rican, etc.)		Race - American Black, White, etc. ecify: Whit	
al E		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		16b. Kind o	f Business/Indus	try
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	To Be (17. Father's Name (First, Middle, Last) Harry I. Warde	r			Belle		ie		
f Health and Mer tem 27 is marke other traumatic	1	19a. Informant's Name/Relationship (T)		100	ng Address (Street					nde)
m 27		Elizabeth Warde	r Wife	1 P	ine St.	, India	an Head Date	20c. Location	on - City or Town	. State
If ite		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ F	Removal from State	emetery, crei	osition (Name of matory or other place Memori	March_	12, 200	14		
Department of Heali Important: If item 2 eny injury or other once.	1	* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		25	Name and Addre	ss of Facility			dorf,	===-0;
Depa Impo eny ii		21. Signature of Fulleral Service Licens	M006	68	William 4270 HA	s Fune:	ral Hom	e dia	A. n'Head.	. Md.20
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be executed ician and burial-transit	al Examiner	Soque tiaty ist condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence)		CAMO	onyo h	47174			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 4:28 P M Wheatle Marc Herbert Ira 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4915 Harrison Ferry Road Hurlock Dorchester 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 9,1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 11XM 2□ F Director 214-28-3735 73 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4915 Harrison Ferry Road 21643 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Floor Covering and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Installation Company Floor Covering Installer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herman Wheatley Myrtle Venables 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I 4915 Harrison Ferry Road, Hurlock, Maryland 21643 Elizabeth L. Wheatley/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Depertment of Important: If It eny injury or one. 1 Burial 2 □ Cremation 3 □ Removal from State Unity Washington Cem. 3/10/2004 Hurlock, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207. 106 Main Street, East New Market, MD 21631 Pa 1. Enter the disease, or om implication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cel mall manths /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 No ၉ neral Director: After the filled in by the funeral 28b. Time of 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral [1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7232 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary S. DeShields, M.D., 509 Idlewild Avenue, Easton, MD 21601 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene? \(\cap \).

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							Cei	rtificate	of Death		Reg. No.	704	10412
	D!!!		1. Decedent's Name	(First, Middle, L	est)			-		2. Date of Month	Death Day	Year	3. Time of Death
	Physici /Medi		Olethia	a V. W	ard					March		2004	3:35 pm
	Examir		4a. Facility Name (If	not institution, gi	ve street and no	ımber)			4b. City, Town	or Location of De	ath 4c. Cour	ty of Death	
			Alice H	Byrd Taw	es Nurs	ing Home	9		Crisf	ield	Sc	merse	t
	Funeral Director		5. Social Security Nu 215-05-89		Sex 1□M 2 <mark>⊠</mark> F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Y Months Da		Hrs. 8. Date of I (Month, NOV •	Birth Day, Year) 23, 1900	9. Birthp Cour Ma.	place (State or Foreign http:// ryland
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h with th	23a or 28 at be no	al Dire	10e. Street and Num 201 Hall					10f. Zip Co	de 21817		10g. Citizen o	f Whet Cour S.A.	ntry?
d 21215-0020 / W.	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 ☑ Widowed 4		Armed F 1 ☐ Yes If Yes, G	2 X No ive		Was Decedent f Yes, specify 0 I ☐ Yes 2 🕱	of Hispanic Origin Cuban, Mexican, P No <i>Specify:</i>	? (Specify Yes or I uerto Rican, etc.)	В	ace - Americ ack, White, ify: Wh:	etc.
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Maryland 21215-0020	Aental tricked of	To Be		W. Tow	•					Townser		iiiie)	
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Nd 2	alth a 27 Is r tra		Lucy But	ler	ρ.r.		1504	Rivers	ide Dr.,	Salisbur	rv. MD	21801	
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Baltimore,	ment o ant: If i		1 ABurial 2 ☐ 4 ☐ Donation 5				y Rid	ge Memo	rial Parl				
Baltimo	Import any In		21. Signature of Fundament	eral Service Lice	nsee				ddress of Facility st St., (Home I 1613	P.A.
			23a. Parti Enter the shock, or heart	disease, or com	plications that	caused the death	. Do not ente	er the mode of	dying, such as car	diac or respiratory	arrest,		Approximate
Phy	ysician		shock, or near	Tallule. List only	One cause on	each line.							Interval Between Onset and Death
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Division of Vital Records, P.O. Be or Attending Physician: The law requires that the death	been sign should be	Completed by	anes	nia	•						is en eutopsy formed?	eva	ere eutopsy findings ailable prior to appletion of cause
Sec.	2 5	ם										of c	déath?
E &	pag	S								1 🗆	Yes 2 No	1 🗆	Yes 2∭ No
of Vita Physician:	is certificate director, pag	Be	25. Was case referre examiner?	d to medical	41 24 4					Death (Check only	one)		
Dysic D	O 50	2	1 ☐ Yes 2 🗷 N	0	Hospital: 1 🗆	Inpatient 2□ E	R/Outpatient	3LI DOA		g Home 5□ Res	sidence 6 □Ot	her <i>(Specify</i>)
7 G	n. After th funeral		27. Manner of Death 1 Manual	5 Pending	28e. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. I	njury at Work?	28d. Describe	how injury occu	rred	
Vision Attending	he for	atic	2 Accident	investigatio		10		М	1 ☐ Yes 2 ☐ No				
V. Atte	by t	₩	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b determined	200. Place	of Injury - At horing, etc. (Specify)		et, factory, offi	ce	28f. Location City or To	(Street end Num own, State)	ber or Rural	Route Number,
	ed in	Certification:									, 21.117		
Hospital	within 24 hours after deam. To the Funeral Director: A completely filled in by the f	edicai	29a. Certifier 1 (Check only 2 one)	☑ Certifying Ph ☐ Medical Exar	niner: On the b	best of my know asis of examination	rledge, death on e nd/or inv	occurred at the estigation, in m	e time, date and play opinion, deeth o	ace, and due to the courred et the time	e cause(s) and m e, date and place	anner as sta	ated. the cause(s)
To the	o th	Z E	29b. Signature and tit	le of certifier	7 1	>		29c. Lic	ense number		29d. Date sign	ed (Month, L	Day, Yeer)
F 3	> ⊢ 0		1900	24	6 15	00) 7	29505				
•		-	reg	aru 1	a. Ile	x coze	ne		21100		03-1	1-2	.004
		+	30. Name and addres				770	CLICA	MOCEN	ita A		2 V 34	
			GREGOR 31. Date filed (Month,		CLLOS	Register's Signat	5 30	~ CHIN	MOCKKY	VK., 51	4 L (S)5 (R)	-7, M	D 21801
	Sta Registr		OT. Date filed (INOTH),	MAR'1	6 2004	degistar's Signati	K	book					
	Tic glotti					0.000	-	SAITS TO					

DHMH 16 Rev 6/95

Addi 04-0	e Wil 1755	LLi	ams Please	Type or Print in Blac	k Indelible Ink.	Ensure All	Copies A	re Legible.	
MAN	1/33		. For	State of Maryland /	Department of H	lealth and Me	ental Hygie	ne a no	10170
			State Registrar		Certificate of	Death	Reg	No.2004	104/3
	hysicia	an.	1. Decedent's Name (First, Middle, La.			1	2. Date of Death Month	Day Year	3. Time of Death
1	/Medic			rae Willia		15 1	March 0		2333 P M
	Examin	er	4a. Facility Name (If not institution, giv 974 Edmund Stree		4b. City, Town, o	r Location of Death		4c. County of Death	
			5, Social Security Number 6. S		irthday) If Under 1 Year	If Under 24 Hrs.	B. Date of Birth	9. Birth	nplace (State or Foreign
	ineral rector	6		□M 210F 43	Yrs. Months Days	Hours Min.	(Month, Day, Y	1 1 1 1 1	ary land
			Usual Residence of Decedent	100 City To	un or t coation			, , ,	10d. Inside City Limits
anylar	ehow ta st	'n	10a. State 10b. County	_ 1	wn or Location				1 Yes 2 □ No
d 21215-0036 MLC filed with 172 hours after death with the Maryland Hydiene.	el', or Items 23a or 28a-f ehow Examiner turst be nutified at	by Funeral Director	10e. Street and Number	-ord A	10f, Zip Code		100	. Citizen of What Co	untry?
\mathcal{L}^{4}	23a or ust be	ā	974 Edm	und Choo	+ 2	1001		1151	Δĺ
Se at	Items 2:	era	11. Marital Status	12, Was Decedent Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Spec	ify Yes or No-	14. Race · Ame	
after a	or Ite	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 212 No	Specify:	ican, etc.)	Black, White	a, etc.
303		d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:				12/	ack
5-0 12-1	nati	lete	15. Decedent's E (Specify only highest gra		a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of working d)	9 16	b. Kind of Business/	Industry
21215-0036 ad within 72 hours aft rgiene.	then re M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Houseke			MATO	1
d 212 filed with Hygiene.	ent, I	Be C	17. Father's Name (First, Middle, Last		1003076	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
ylan ould be Mental	rked tic ev	To B	Moses 1	Nilliams		Onei	da V	ates	
F 5 5	is marked other then aumatic event, It's M		19a. Informant's Name/Relationship (b. Mailing Address (Street		Route Number, C	ity or Town, State, Z	(ip Code)
and a	Important: If Item 27 is marked other then "naturany injury or other traumatic event, the Medical poce.		Raymond	yates 9	74 Edmu			en, Mary	Jana 21001
Ore 1 Sec 1	If Iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State cemet	of Disposition (Name of ery, crematory or other place			c. Lozation - City of	Town, State
Baltimore, bermit. Pages 1 a	tant:	-	*4 □ Donation 5 □ Other (Special	m Buck	town Cemer	LERY 3/14	0/04 C	ambridge	Maryland
Bal:	mpor any in		21. Signature of Funeral Service Lice	nsee	22. Name and Addre Hewry Fu 510 Wash	Neral Ho	Me, P. A.	. 1	21/12
			23a. Pant Enter the disease, or com	polications that caused the death. Do	not enter the mode of dvir	ng. such as cardiac or	camb n	1 dg (2) /V/1	Approximate
	43		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	71	1	1:	í	Interval Setween Onset and Death
Pr.	sician edical		disease or condition resulting in death)	a. Due to (or as a consequence		to empe	211		
Exa	miner								
	a chi	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	B of):				
cutec	an and irial-transit	Examiner	Cause (Disease or injury that initiated events	c					
30, 8 exe		= 1	resulting in death) Last	Due to (or as a consequence	B of):				
6876	ig physici as the bu	dlca		d					
X 6	Q (4	by Physician/Medica	IF FEMALE:	23c. If yes, outcome of pregnancy				23d. Date of deli	verv
Box leath cert	ed by the attendir detached for use	clar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live birth 2 Fetal dea 4 Pregnant at time of death	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	/		Month	Day Year
P.O.	by the tached	hysl	9 Unknown	9□ Unknown					
S, Tha	signed l	oy P	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause giv	ren in Part I.	23e. Did tobar	cco use contribute to	
ordine against	been sig		Dread Car	unous met	25/2/766		1 🗆 Yes	2 2No 3 Pr	obably 4 Unknown
aw re	as be 2 sho	plet					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
H Pu	cate has t page 2 s	Completed					12 Yes 2	deatb?	2 No
Division of Vital Records, P.O. Box 6876 or Attending Physician: The law requires that the death certificate by affect death	After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Outpations 351 DOA Ott	26. Place of Death			
Of O	this or	2	ty⊒y'es 2 □ No 27. Manner of Death	1 Impatient 2 EH/C	outpatient 3 DOA	4 Nursing Holli	e 5 🗌 Residend 3d. Describe how		eify) At scene
on ging	After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Wor	rk? Yes 2 □ No	70. 2000.100 How	mary occurred	
/iSiO	octor.	fica	3 Suicide 6 Could not b	28e. Place of Injury - At home,	farm, street, factory, office	21	Bf. Location (Stre	et and Number or Ru	ral Route Number,
Di alla	od in t	Certification:	4 ☐ Homicide determined	building, etc. (Specify)			City or Town,	State)	
Division Division To the Hospital or Attendation Autor affect death	To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying P	hysician: To the best of my knowled miner: On the basis of examination a	ge, death occurred at the time	me, date and place, as	nd due to the caus	se(s) and manner as	stated.
the H	the F	Medi	one	and manner stated.					
P = \$	To	~	29b. Signature and title of certifier	000	29c. Licens			I. Date signed (Monti	
		12	746			.M.E.		March 10,	2004
		1 17	30. Na se and address of person who	completed cause of death (Item 23a		Stroot P	al+imax	Marralan	a 21201

State Registrar

	•	1 - For State Registrar	State of Maryl		artment of I rtificate of		Re	g. No. 2 U U 4	
hysici: /Medic		Decedent's Name (First, Middle, La. Raymond Thomas					2. Date of Death Month MARCH	9, 2004	11:20A
Examin		4a. Facility Name (If not institution, give			4b. City, Town, Cambri	or Location of Deat	h	4c. County of Dec	
uneral		3015 N. Skipjack 5. Social Security Number 6. S	Sex 7. Age (In)	vrs. last birthday)		If Under 24 Hrs		9. Bi	rthplace (State or For country) aryland
rector		Usuel Residence of Decedent	32				Aug. 20,	1551 13	10d. Inside City Lin
a pow	jor	10a. State 10b. County MD Dorche		City, Town or Lo		ridge			1 Tyes 2 X
or 28a-	Funeral Director	10e. Street and Number	als Desires		10f. Zip Code	21613	10	g. Citizen of What C	Country?
ns 23a	erai	3015 N. Skipja	12. Was Decedent Ever i	n U.S. 13.		ZTOTO Hispanic Origin? (Sban, Mexican, Puer	Specify Yes or No-	U.S.A.	
other than "natural", or items 23a or 28a-1 ahow vant, the Medical Estraturant has be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Ovorced	Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates:		If Yes, specify Cul		to Hican, etc.)	Black, Wh	white
"natur	letec	15. Decedent's E (Specify only highest gra	ade completed)	16a. Dece (Give	edent's Usual Occu e kind of work done DO NOT use retire	ipation a during most of wo ad)	rking	6b. Kind of Busines:	s/Industry
urthan tra.M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		carpente	r		home impr	ovement
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raumatic av		19a. Informant's Name/Relationship (Type, Print) mother			ot and Number or Ri 68, Cambr	ural Route Number,		Zip Code)
Item 27 other tr		Janice Wright 20a. Method of Disposition			osition (Name of omatory or other pla			21613 Oc. Location - City o	r Town, State
ant: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special	_Hemovai from State		y Cremat		1/04 s	alisbury,	MD
Important: If Ite any injury or o once.		21. Signature of Funeral Service Lice		2	2. Name and Addr	ress of Facility T	homas Fun ambridge,	eral Home	P.A.
sician ledical aminer		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a con		shot w	ound of	head		Interval Between Onset and Deat
attending physician and for use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor						
by the attending phy tached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pro 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnan: □ Other (specify)	су		23d. Date of d Month	elivery Day Year
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ate has been sig page 2 should b	Completed						24a. Was an autopsy perform 1 X Yes 2	prior to led? death?	autopsy findings avai completion of cause s 2 No
certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	2 EB/0 1 1	2004 0		ath (Check only one		SCENE
After this funeral di	ertification: To	1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time (Injury) Found (1:	of 28c. Inj	4 🔲 Nursing i	28d. Describe how		
F: A ⊕ †	tifice	3 Suicide 6 Could not to determined		At home, farm, si		9	28f. Location (Str. City or Town,	eet and Number or F State) 3015 /	Rural Route Number, V. Skip jack
el Director: A	Cer		byeiging: To the best of my				e, and due to the cau urred at the time, da		
Funeral Director: A	O		miner: On the basis of examiner stated.	mination and/or i					
To the Funerel Director: All completely filled in by the fu	Medical Cert	(Check only one) 2 Medical Exa	miner: On the basis of exam	milation and of a		.M.E.		ARCH 10,20	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3 O4 **Physician** 4130 AM Wh:tE UNICE 21 KEllam /Medical 4a. Fecility Name (If not institution, give street and number) le: City, Town, or Location of Death 4c. County of Death Examiner 30686 LANE JONES | Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 8. Date of Birth (Month, Pay, No. 2 - 10) rincess OMERSE 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 254E Months 68 Yrs. 220-32-7834 Director Usual Residence of Decedent 10b. County 10e-Sity, Town or Location 10d. Inside City Limits with the Maryland 10a. State r than "naturel", or items 23s or 28s-1 show the Maxical Examiner must be notified at 1 Mes 2 No MD OMERSET trincess Director Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? A2.U 21853 30686 ANE CONES Funeral death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status filed within 72 hours after 1 Never Married 2 Married K lack Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 114 ladgma. -ABORER other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be of Health and Mental H fitem 27 is marked oth r other traumatic aven Pages 1 and 2 should be Morris lhomas JERAID: NE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30686 JOHES 21853 Princess > - JON MD William E. White Jr. Thre 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: if ites
sny injury or ott
QDC6. 1 Surial 2 Cremation 3 Removal from State John Wesley Cemercy 3-27-04 to Anthony E. Ward Funeral He 30639 Hampen Anthony Princes -27-04 Princess * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Homo MD 21853 Anne, 27. Approximate Interval Between Onset and Death Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dira **Physician** OYL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner nagea the burialphysician P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 90 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 🗌 Yes 1 ☐ Yes 2 ☐ No 2/1 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Atter Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the 3 Suicide

or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death To the Funerel Director: in by t Hospital

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title orcertifier 29c. License numbe 29d. Date signed (Month, Day, Year) March 22, 2004 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Elm Street, Princess Anne, Manyland 21853 Hamlette, M.D 1213 Steven 32. Registra Signature 31. Date filed (Month, Day, 2004 **ORIGINAL**

State Registrar

Medical

To the h

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 **Physician** IVER 09:06 A.M JAMES 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner FOCOMOKE** HARTLEW HALL WORCESTER urs:no HOME 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 12-18-19 **Funeral** 1**⊠**M 2□ F 83 Yrs. 219-07-2884 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location in than "natural", or Items 23e or 28e-f show the Medical Evant art must be notified at 10d. Inside City Limits MD Worcester Director 1 XYes 2 □ No OcomoKE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 813 21851 U.S. A filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 25No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 15-lack 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -ARM AboRER othar 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: if item 27 is marked oth any jury or other traumatic event song. 18. Mother's Name (First, Middle, Maiden Sumame) WARD -LIVER aura. 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A. Ward -813 Ind ST. to como la City. 20a. Method of Disposition MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Poco Moke, ST. James U.H.C. Cembery * 4 ☐ Donation 5 ☐ Other (Specify) 3-27-04 22 Name and Address of Facility Anthony E. Ward Funcial Home 30639 Hampden Au. Princess. 21. Signature of Funeral Service Licensee MD 2-1853 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metabolic **Physician** /Medical Due to (or as a consequence of): Live Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy signed by the atter in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 📉 🗸 🗸 🗸 🗸 O 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ◯ No To the Hospitel or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifiel 29c. License number 29d. Date signed (Month, Day, Year) Som 3-17-04

DHMH 17 Rev 1/2001

State Registrar 5%.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

006 - Mark

31. Date filed (Month, Day, Year)

Observator		For Amend Item Registrar 1. Decedent's Name (First, Middle, Las					2. Date of De		3. Time of Death
Physicia Medic/		Virginia E	lizabeth	Wolfe	9		Marek		4 2:15 A
Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or		th	4c. County of De	
		Washington Cou		ital In yrs. last birthday)	Hage	rstown	9 Date of Bird		ington
uneral irector			ам жоғ 1286		Months Days	Hours Min.		y, Year) 9. 60	rthplace (State or Fore Country) Snnsylvania
rector	-	Usuel Residence of Decedent	1 00				1 entroat	y 1,1310 P	ennsy i vania
how		10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Lim
alfile.	cto	Maryland Washing	ton	Hagerst	own				1 □XYes 2 □ I
or 25	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	•
or itema 23a or 28a-1 ahow intrat must be rediffed at	Funeral Directo	1500 Pennsylva			2174			U.S.A.	
tten.	- ru	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 ☐ No	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer	to Rican, etc.)	14. Race - Am Black, Wh	
	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2⊅No	Specify:		Specify: M	hite
"natural", dical Eva	ted	15. Decedent's Ed		16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busines:	
- 3	Completed	(Specify only highest grad	College (1-4or 5+)		kind of work done of DO NOT use retired	during most or wo	rking		
other than	Sol	8		Hoi	nemaker			Own Hom	e
d oth	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
marked imatic ev	ှင	James Russ		rmack		Ida	May	Rober	
item 27 is marked other than other traumatic event, I.a.M.		19a. Informant's Name/Relationship (7						or, City or Town, State, DWn, Maryla	
am 27		James L. Wolfe 20a. Method of Disposition	Son	20b. Place of Dispo		Averiue,	Date	20c. Location - City o	
= 5		1) Burial 2 Cremation 3	Removal from State	cemetery, crer	natory or other place	'			
mportant: any injury once.	1	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 			1 Cemeter		27-04	Hagerstow	∕n, Maryla⊓
importa any inju once.		-R. hoel br	ader	A	ndrew K	Coffman	Funeral	Home, Inc. estown, Md.	21740
- F		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused th	e death. Do not ent	er the mode of dying	g, such as cardia	c or respiratory ar	rest,	Approximale Interval Between
sician		Immediate Cause (Final	0	•			1	/	Onset and Death
edical		disease or condition resulting in death)	a. Pue to (or as a c	onsequence of):				<i>I</i>	4 weeks
miner		Soquentially list conditions	h con	gestive	heart =	failing	1/1//		Unknows
Ħ	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a o	onsequence of):			1/16	CAL EXAMINER	
and -trans	Examin	that initiated events resulting in death) Last	c. Del	alea 0	ardiom	topathy	- PRYME	OLCHO	Years
hysician and the burial-transit			Due to (or as a o	roll Lit	- Ylation		NAPPROVE		years
physical the I	edicai		d	100 708	31/00011	CERTIFICATI			years
attending ph I for use as th	/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of de	livany
atter I for u	Physician/M	in the past 12 months?	1☐Live birth 2 [4☐Pregnant at tin	Fetal death 3	Ectopic pregnancy Other (specify)			Month Month	Day Year
y the	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
been signed by the should be detached	by PI	Part II. Other significant conditions co	ntributing to death but r				23e. Did to	bacco use contribute t	o the cause of death?
an sig	ed b	Paraplegia due t	o Cerebrova	ale Enl	wocht	15	1 □ Y	es 2□No 312P	robably 4 Unkno
s bee	Completed	rarapregra due t	CELEDIOVA CARA	iscutat ac	cruent		24a. Was a		utopsy findings availal
page 2	EO	(h.m	i obstrui	twe lun	a disea	se	autop perfor 1 Yes	med? death?	completion of cause
certificate rector, pag	BeC	25. Was case referred to medical examiner?	003/10/0				ath Check on or		23.10
his ce I dire	To	1 X Yes + Sto	Hospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Othe	er: 4 🗆 Nursing H	lome 5 Resid	ence 6 Other (Spe	acity)
fter tl		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	28c. Injury Work	at c?	28d. Describe h	ow injury occurred	
¥ 2	cati	2 ☐ Accident investigation			M 101	Yes 2 □ No			
\$ e	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (At home, farm, stre Specify) 	eet, factory, office		28f. Location (S City or Tow	itreet and Number or R m, State)	ural Route Number,
irector in by the		On One of the other of the othe	To the best of				-11		
eral Director		29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of r iner: On the basis of ex and manner state	amination and/or inv	occurred at the time restigation, in my op	ie, date and place pinion, death occu	e, and due to the d erred at the time, o	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
Funeral Director stely filled in by the	dica	4	and market states	J	100-11			29d. Date signed (Mon.	th Day Year)
o the Funeral Director ompletely filled in by the	Medical	29b. Signature and tyle of certifier	١		29c. License	aumber -			
To the Funeral Director: After this certific completely filled in by the funeral director.	Medica	29b. Signature and tyle of certifier	1						
To the Funeral Director completely filled in by the	Σ	30. Name and address of person who can be seen as a seen	ompleted cause of deca	h (liam 23a) (Type	D44	996		March 24	1, 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month ĭ3 Susan G. Weitzel March 2004 A^{M} 9:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 203 Nottingham Hill Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days 1 M 250F Hours 58 Director 259-68-1704 1945 June 2, Texas Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits item 27 is marked other than "natural", or Iteme 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at Maryland Anne Arundel Annapolis Director 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Nottingham Hill 21405 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Interior Designer 1 Interior Design 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill iment of Health and Mental Hitant: If item 27 is marked out Be William A. Glass Jacque Lansdale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Weitzel/husband 203 Nottingham Hill Annapolis, MD 21405 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ö 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Baltimore Crematory 3/16/2004 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signatura Meral S 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester Annapolis, MD 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Non-Hodgkin's Lymphoma **Physician** $1 \frac{1}{2} \text{ yrs.}$ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, the attending physicien Physician/Medical the as use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ō 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) detached i 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ be Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? certificate 2 🗆 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home **SXX**Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 XNatural Injury within 24 hours after wear.

To the Funeral Director: Alt 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18909 (NE) March 15, 2004 ichos() 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael R. Bishop, MD 10 Center Drive Bethesda, MD 20892 31. Date filed (Month, Day, Year)

MAR 1 6 State Registrar

			1 - State of Ma	ryland / Depa <i>Cei</i>	artment of H tificate of			ene 3. No. 2004	10479
	Physici		1. Decedent's Name (First, Middle, Last) Ethel A. Wells				2. Date of Death Month March 1	Day Year 2 2004	3. Time of Death
1	/Medic Examir		4a. Facility Name (If not institution, give street and number) 1812 G. Copeland Street		4b. City, Town, o	r Location of Death		4c. County of Death Anne Aru	
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 日 M 発展 6	(In yrs. last birthday) 6 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day,) Aug. 24	(ear) 9. Birth	place (State or Foreign intry) ryland
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-1 show appringuy or other traumatic event, it is Madical Examination that traumatic event, it is Madical Examination.	by Funeral Director	Maryland Anne Arunde1 10e. Street and Number 1812 G. Cope1and Stree 11. Marital Status 1 Never Married Mar	ver in U.S. 13. V	1 S 10f. Zip Code 2140	dispanic Origin? (S an, Mexican, Puert		J. Citizen of What Cou USA 14. Race - Ameri Black, White Specify: B1	can Indian, etc.
21215-0036	filed within 72 hour Hygiene. khar then "neturel ent, the Medical E.	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th 0	(Give life. L	dent's Usual Occup kind of work done DO NOT use retired Omestic	during most of wor	king	Sb. Kind of Business/Ir	·
Maryland	should be fill and Mental H ind marked oth	To Be	17. Father's Name (First, Middle, Last) George Hopkins 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	Mar	ne (First, Middle, Ma tha Brow Tal Route Number, (C Code)
Baltimore, Ma	Pages 1 and 2 s nent of Health ar int: If item 27 is iry or othar trau		Patricia Randall (Daugh: 20a. Method of Disposition 120 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ter) 62 20b. Place of Dispo- cemetery, cren Bestgate	Island Sition (Name of the natory or other place	d Croek	Ct. Ann	apolis, 2 c. Location - City or T	M1 21401 own, State
Baltir	permit. F Departme Importar eny injur		21. Signature of Funeral Service Licensee Jarry J., Beese Mod	Park 22 Wr	Name and Addre	ss of Facility	Particular Control	nnapolis ry, ^P .A. Md. 2140	
8760,	by Medical be executed with the state of the	dicai Examiner	resulting in death) Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Cause, Chisease or injury that initiated events Due to (or as a Due to (or as a Due to (or as a Cause, Chisease or injury that initiated events	consequence of):	or the mode of dying	g, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death 3 Q YCA 5
Box 6	that the death certific, ned by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 Yes Yes, outcome or 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of deliver	ery Day Year
rds, P.O	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Dther significant conditions contributing to death but Brish Libert la	not resulting in the un	derlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to the	he cause of death?
al Records,	ilcian: The law re certificate has be rector, page 2 sho	e Completed	Chronic Anemia					prior to co	psy findings available mpletion of cause of 2000
Division of Vital	Attending Phys ir death. actor: After this by the funeral di	Certification: To Be	27. Manner of Teath 1 Natural 5 Pending (Month, Day) 2 Accident investigation investigation	/ - At home, farm, stre	28c. Injun Worl M 1	er: 4 Nursing H	28d. Describe how	et and Number or Rura	
ā	To the Hospital or A within 24 hours after To the Funeral Dira completely filled in b	edical Cer	29a. Certifier (Check only one) Check only one) Check only (2 Medical Examiner: On the basis of early manner state)	my knowledge, death xamination and/or inv	occurred at the timestigation, in my o	ne, date and place, pinion, death occur	and due to the caus	sa(s) and manner as e	lated.) the cause(s)
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier 30. Name and address of person who completed cause of deal	th (Item 23a) Times	29c. License	1586	3	Date signed (Month,	Day, Year)
*	Sta Registr		Tharm Me MESSIES	s Signature	Admi	ral Co	chome.	Og Anna	polis, Meso

			_ [-0]	epartment of Health and N Dertificate of Death		giene Reg. No. 2004	10480
			Decedent's Name (First, Middle, Last)		2. Date of Dea	ath	3. Time of Death
3	Physicia	_	Adell Walker		Month March	7 2004	1:30 a ^M
	/Medic Examin	2.4	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			10 Domino Road	Annapolis		Anne Aru	ındel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min.	8. Date of Birt (Month, Da	ıy, Year) Coü	
	Director	-	137-14-2079 94	rs.	July 1	3 1909 Vir	ginia
	pud *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	lanyla sho	٥		4.1.			1 ∑Yes 2 No
	28a-1	Director	Maryland Anne Arundel Annapo	10f, Zip Code		10g. Citizen of Whal Cou	intry?
	with with		10 Domino Road	21401		USA	
	ins 2%	era	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No	- 14. Race - Ameri	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	by Funeral	Armed Forces? 1 ☐ Never Mamed 2 ☐ Married	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ★ No Specify:	o Hican, etc.)	Specify: B15	_
Ö	2 hou	ted		Decedent's Usual Occupation	trine	16b. Kind of Business/Ir	ndustry
7	Nedi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of work life. DO NOT use retired)	king		
21	d with	mo;		Beautician		Hair Salo	on
פ	al Hy I oth	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle,	, Maiden Sumame)	
<u> </u>	Ment Ment arke	2	Mason Adkins		n S. D		
Maryland 21215-0036	2 sho	4		Mailing Address (Street and Number or Ru			
	and lealth m 27 her t			906 Spa Road Anna Disposition (Name of	polis,	Md. 2140]	
0	ges 1 If of H If its or of		POBurial 2 Cremation 3 Removal from State Beston	r, crematory or other place)		200. Education - Only of T	own, otato
Baltimore,	urtmer prent: prent: njury		*4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	3/11 22. Name and Address of Facility	/04	Annanclis,	. Md.
Ba	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 9069.		Lavy D. Reese mo0483	Wm. Reese & Sons	apolis	. Md. 2140	
В		, 1	23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	it enter the mode of dying, such as cardiac	or respiratory ai	rrest,	Approximate Interval Between Onset and Death
	Physician	Ŭ.	Immediate Cause (Final disease or condition resulting in death)	rath			
п	/Medical Examiner	22	Due to (or as a consequence of				
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	ted nsit	ulu e	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0			
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8760,	icate be executed physician and s the burial-transit		d				
9	tificat ig phy as th	edi					
Box	ndin use	S V	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 ☐Ectopic pregnancy		23d. Date of deliv	•
		Physician/Medical	in the past 12 months? 1 Pregnant at time of death	5 Other (specify)		Month	Day Year
P.O.	that the ed by ti detach	Phy	9 Unknown	the confidence as an arrange in Part I	23a Did t	obacco use contribute to I	the cause of death?
Division of Vital Records,	es pe	þ	Part II. Other significant conditions contributing to death but not resulting in	ine underlying cause given in Fart i.		Yes 2 12 No 3 □ Pro	
000	law requir as been s 2 should	Completed			24a. Was autop	an 24b. Were auto	opsy findings available ompletion of cause of
Ä	0 = 0	E			perfo	rmed? _ death?	2₽10
ital	ician: Th certificate ector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Dea	ith (Check only o	one)	
	Physician: this certific ral director.	10	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Other: 4 Nursing H	ome 5 A Resid	dence 6 Other (Speci	fy)
20	ding PI h. After th		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) In	jury Work?	28d. Describe I	how injury occurred	
sio	Attending r death. actor: After	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home far	M 1 Yes 2 No	206	S	
Divi	al or Atteno after death Diractor: d in by the	Certification;	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 28e. Place of Injury - At home, fair building, etc. (Specify)	n, street, factory, office	City or To	Street and Number or Run wn, State)	ai Houte Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.				
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month,	Day, Year)
	F > F 0		0.1(10)	043231		3/10/1	4
			30. Name and address of person who completed cause of death (Item 23a) (v	, –, –	
			2448 Holly Ave., Ste 100	Anapolis	mp	2140/	
1	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 0 2004 32. Refistrar's Signature	book			

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mar 23, 2004 Physician 8:00 pm Weaver Harold /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland 24 Moran Avenue Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, May 28, 9. Birthplace (State or Foreign **Funeral** 1₩ 2□F MD (Cotry) **1**927 76 Director 213-24-5613 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be nutified at Cumberland Allegany MD 1 Nes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or USA 21502 24 Moran Avenue filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Aes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3 □ Widowed 4 □ Divorced "netural", WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Importent: If Item 27 is marked other than "ne any injury or other traumatic event, Ins Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor **Ballistics** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clara Clark Weaver Jesse Harold Weaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18628 McMullen Hwy Rawlings MD 21557 19a. Informant's Name/Relationship (Type, Print) **David Weaver** son Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State 3/26/2004 MD Rocky Gap Veterans Cemetery **Flintstone** * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Namsand Address Furtheral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not need the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line. Approximate Interval Between Onset and Death Immediate C use (Final disease or condition resulting in death) **Physician** /Medical Dusto (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit 0 5 the attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 I Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 2 Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 NO released 25. Was case referred to medical examiner?

14. Yes 2 \sum No Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signatural and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54411 3-24-04 me and address of per on who completed cause of death (Item 23a) (Type, fint) 500 Memorial Ave Ste 105 Cumberland MD Beverly Calkins M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 200 Registrar

			1 - For State Registrar	State of	Maryland	d / Depa <i>Cei</i>	artment of H	ealth and Death		giene 2	004	10482
			1. Decedent's Name (First, Middle	, Last)					2. Date of De	ath		3. Time of Death
	Physici /Medio		William	Laure	ice		Young		March	13,	2004	9:10 P M
	Examir		4a. Fecility Name (If not institution				4b. City, Town, or	Location of Dea	ith	4c. Cou	inty of Death	
		Η.	Sunrise Assist				Severna				Arund	e1
	Funeral Director		5. Social Security Number 284–36–8245	6. Sex 1 → M 2 □ F	7. Age (In yrs. la 64		If Under 1 Year Months Days	If Under 24 Hr. Hours Mir		th by, Year) 1940	9. Birthp Cour Ohio	elece (Stete or Foreign htry)
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation			-	1	0d. Inside City Limits
	Mary fah	ট্	Maryland Anne A	runde1	Davi	dsonv:	i 11a					1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number	I dild C I	Davi	usonv.	10f. Zip Code			10g. Citizen	of What Coun	ntry?
	th with	a D	3955 Wayson Roa	d			21035			U.S.A		
	ams	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S	. 13. V	Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (Specify Yes or No	- 14, F	Race - Americ	
036	should be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or Itams 23a or 28a-f ahow marked other than "natural", or Itams 23a or 28a-f ahow marked other than "natural".	by	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 🛣 Yes	2 □ No		☐ Yes ЖX No	Specify:	110 110411, 010.7		ocify: Wh	
2	72 h	Completed	15. Decedent (Specify only highes	's Education it grade completed)		(Give	ent's Usual Occupa kind of work done d	uring most of we	orking	16b. Kind of	Business/Inc	dustry
121	within ne.	mp	Elementary/Secondary (0-12)	College (1-		life. L	OO NOT use retired)		J			
2	filed Hygie Hygie other f		17. Father's Name (First, Middle,	<u> </u>		матпет	natician	18 Mother's Na	me (First, Middle,		ernment	
a	d ta b	To Be	Laurence	J.	You	ng		Margare		В.	,	auffer
Maryland 21215-0036	2 8 8 3		19a. Informant's Name/Relations				g Address (Street a					
a,	jes 1 and 2 of Health If item 27 or other tru		Patricia A. You 20a. Method of Disposition 1 Burial 2 Tremation		20b. Pla	ce of Dispos	Jayson Ros sition (Name of natory or other place		idsonvill Date		ryland n - City or To	
Ĕ	Pages tment of tant: If it jury or o		' 4 □Donation 5 □ Other (S)	pecify)			ematory		5/2004		f, Mar	
Bai	permit. Pages Department of t Important; If ite any injury or of once.		21. Signature of Funeral Service	icensee			Name and Address					11 Home 20715
			23a. Pert1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that ca	used the death.		or the mode of dying	, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
,	Physician /Medical		disease or condition resulting in death)	a. Hay	or as a conseque	once of):	1 thei	mers	dam	entri	a	years
	Examiner		P	F	, , , , , , , , , , , , , , , , , , , ,							O
1000	ם ש	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a conseque	nce of):						
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to /c		ann of						
8760,	death certificate be executed e attending physician and id for use as the burial-transit	ai E		Due 10 (C	or as a conseque	псө от):						
289	ificate g phys	edicai		d								
ROX	eath certific attending p	M/u	IF FEMALE: 23b. Was decedent pregnant		ome of pregnand th 2 ☐ Fetal d					23d. [Date of deliver	v
o o	e deat	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nt at time of dea		Ectopic pregnancy Other (specify)				Month I	Day Year
	hat the de d by the a setached	Phy	Part II. Other significant condition			inn in the	d-4 :	- i- G. Al	OO - Distan			
ecords,	w requires that been signed b should be deta	ted by	anni omor significani osnano					nin Panti.		obacco use co ′es 2 □ No		a cause of death?
ပ္	law as b 2 si	ompieted							24a. Was a		prior to com	sy findings available apletion of cause of
	Page 1	Co							perfor	med? 2 No	death?	2□ No
VITA	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other		ath (Check only or		/	Assited _
		1: To	1 Yes 2 No	1 In 28a. Date of	patient 2 EF	NOutpatient 8b. Time of	3□ DOA Other	4 Li Nursing F	lome 5 ☐ Resid			Living
0	를 근존 글	ation	1 Vatural 5 Pending	(Month	, Day Year)	Injury	Work	es 2 No	Loc. Doscribe in	ow injury occi	unea	
JIVISION	r Attendii er death. ractor: Ai by the fu	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	289. Place	of Injury - At hom g, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Nun	nber or Rural	Route Number,
ב	ital o	Cer		Щ					1			
	To the Hospital or Atten within 24 hours after death To the Funeral Diractor.	edicai	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the t xaminer: On the bas and manne	sis of examination	edge, death n and/or inve	occurred at the time estigation, in my opi	e, date and place nion, death occu	e, and due to the coursed at the time, d	ause(s) and r late and place	manner as sta e, and due to	ited. the cause(s)
	To the To the Company	ž	29b. Signature and title of certifier			14 -	29c. License		2	29d. Date sign	ned (Month, D	ley, Year)
7				In		MI) 0	JU/0		3-1	5 - a	004
			30! me and address of cerson w	vho completed cause	of death (Item	3a) (Туре, Р	rint) ars Hw	y Mil	lers vil	le n	11)	71108
, Ale	Sta Registra	-	31. Date filed (Month, Day, Year)	6 2004 32. Ro	strar's Signatur	* A	Courts)					

Amend Item 8,12 per FH,G83C,04/14/04dhb Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2004 10483 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month Year DUBLAS 3:12 AM Mme-MARCH 2004 /Medical 4b. City, Town, or Locetion of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner LtimoRe DALL more If Under 1 Year | If Under 24 Hrs. 8. Date of Birth04/24/24 Month, Day, Year) 24 ATR: 4, 1024 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1⋤M 2□ F 79 216-16-6853 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits al Hygiene. other than "naturel", or items 23e or 28e-f show vent, the Medical Examiner must be notitied at BALTIMORE 1 X Yes 2 □ No MD. N/A Directo 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? U.S.A. 21224 515 S. LEHIGH STREET Funeral filed within 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes Z No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: \$ 3 → Widowed 4 □ Divorced Specify: WHITE Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STEEL PIPE FITTER 10TH 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 end 2 should be filment of Heelth end Mentel Hant: If Item 27 is marked ott ROBERT EMMETT ARTHUR MARGARET HOFFERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 S. LEHIGH STREET, BALTIMORE, MARYLAND 21224 MAUREEN SIMMONS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MARYLAND 4/5/04 CEDAR HILL CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licenses 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Physician Congestive Heart FAILURE Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner certificate be executed ng physiclen end es the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of) Box 68760. signed by the attending physiclen d be deteched for use es the buria Physician/Medical Due to (or as a consequence of) resulting in death) Last P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? hes 1 Li Yes certificete 2 1No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after deeth.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 PNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide edicai 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) C-REENE STREET BALTIMURE, MD 21201 B.OAL. FIANAKIS, MD Nichol 31. Date filed (M 3. Registrar's Signature State Registrar

			For State Registrar	State of	Marylan	-	artment of H			giene Reg. No. 2 (nL	101.81.
	Physici /Medic		1. Decedent's Name (First, Middle, Las Mazie F. Bu	•					2. Date of Dea		Year OC	3. Time of Death
	Examir		4a. Facility Name (If not institution, give Franklin Schaff.) 5. Social Security Number () 6. S	e Hospi	ber) to / Ct	ast birthday)	ROS COO	Location of Death	8. Date of Birt	3a /	timo	
	Director		216-01-9579 1 Usual Residence of Decedent	□M 2 X F		91 Yrs.	Months Days	Hours Min.	(Month, Da) June 5,	v, Year)		lace (State or Foreign try) yland
	within 72 hours after death with the Maryland one. than "natural", or Items 23a or 28a-f show than "natural", or Items 21a or 28a-f show ite Madical Expressor in the Institute of the Institute	Il Director	Maryland Balt: 10e. Street and Number 3441 Liberty Park	imore way	10c. City	r, Town or Lo	dalk 10f. Zip Code	222		10g. Citizen of V Unite	What Coun	•
22,6 215-0036	nours after death ural', or Items 2 I Expruirer rous	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nover 4 Divorced	12. Was Deced Armed Forc 1 Yes 2 If Yes, Give Year or Date	es? XX No	1	Vas Decedent of Hi Yes, specify Cubai	Specify:	ecify Yes or No- Rican, etc.)		e - Americ ck, White,	an Indian,
Haz, d 21215-	be filed within 72 hatal Hygiene. d other than "naturesent, ITE Madical	e Completed	15. Decedent's E. (Specify only highest gra Elementary/Secondary (0-12) 9 17. Father's Name (First, Middle, Last)	de completed) College (1-4	tor 5+)	(Give . life. [ient's Usual Occupa kind of work done of 20 NOT use retired, ESS Check	luring most of work)		Westerr	Elec	
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1100 ore, Mi	1 and Health Bm 27 ther t		Blanche Miles - F1 20a. Method of Disposition			3450	York Way sition (Name of patory or other place	Dunda1k			22	
altimo	permit. Pages Department of I Important: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer	y)	ate	clawn (Cemetery Name and Addres adley—Asi	3/30/				Maryland
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8760,	Physician /Medical Examiner but sicial and sicial street s	dicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	b. Due to (or	r as a consequer as a consequer as a consequer	uence of):						
.O. Box 6	that the death certific ed by the attending p detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown		h 2 ∏ Fetal ntattime of de	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Dat Mo	e ol deliver	ry Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Dther significant conditions c	ontributing to deal	th but not resu	ilting in the un	derlying cause give	n in Part I.	23e. Did to			e cause of death?
al Reco	ician: The law requ certificate has been ector, page 2 shoul	Completed							24a. Was a autops perfor 1 ☐ Yes	med?	rior to com leath?	esy findings available apletion of cause of
Division of Vital Records, P.O.	tending Phya eath. or: After this (the funeral dir	Certification: To Be	25. Was case referred to medical examiner? 1 Yes		Injury Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work M 1 \(\triangle Y	at ? es 2 □ No	me 5 □ Reside 28d. Describe h	ence 6 Other	ed	
Div	Aospital or Att		4 Homicide determined 29a. Certifier 1 Certifying Ph	building ysician: To the be	, etc. (Specify) est ol my knov) vledge, death	et, factory, office	e date and place a	28I. Location (S. City or Town	1, State)	nner as sta	ated
150	To the dospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only one) 2 Medical Examone) 29b. Signature and title of certifier	niner: On the basi and manner	is of examinati	ion and/or inv	estigation, in my op 29c. License	inion, death occurre	ed at the time, d	ate and place, a	Ind due to	the cause(s) Pay, Year)
	1		30 Name and address of person who	completed cause	of death (IMA)	23a) (Type, F	Print) Franklin	00000		4/2/2	04.	
	Sta Registr		Dr. Charisee 31. Date filed (Month, Day Year) APR 07 2004	Da Ven	DOFT jistrar's Signat	9000	Franklin :	Square Di	rive Ba	Himore	Md.	2/237

		-	1 - For State Registrar AMFND ITFM #5	State of Marylar	nd / Depa	artment of H	lealth and I Death		ene 2001	10485
			Decedent's Name (First, Middle, Last)	2FR FH 1-830 4/1	O/U4 JH			2. Date of Death Month	Day Year	3. Time of Death
Phys /Me	sicia edica		Margaret	D. B	erger		<u> </u>	April 2		4:00 PM
Exa			4a. Facility Name (If not institution, give st				r Location of Death	1	4c. County of Deat	h
£y			Hill Haven Assis			Adelph	11 If Under 24 Hrs.	R Date of Birth	P.G.	
Fune Direct		İ	5. Social Security Number 6. Sex 1 CONTROL OF SECURITY Number 6. Sex 1 CONTROL OF SECURITY NUMBER 1	M 2√2 F	last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y June 27	(ear) 1910	hplace (State or Foreign untry) PA
ere pe	.01	t	Usual Residence of Decedent				<u> </u>	punc 21	, 1040	FA.
larylano ahow			10a. State 10b. County	10c. C	ity, Town or Lo	ecation				10d. Inside City Limits
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with the M		Director	10e. Street and Number 3210 Powder Mil.	I Dond		10f. Zip Code	N700	100	. Citizen of What Co	untry?
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Thysiene. Thy and "natural", or items 23a or 28s-1 ahow mit. It wested to a server and the matural to collised and the matural to collised and the collision and the collision and the collision and the collision and the collised and the collision and th		Funeral		L NOAG 2. Was Decedent Ever in U	IS 13 V	Was Decedent of h	dispanic Origin? (S	necify Yes or No-	U.S.A.	rican Indian.
iter d		Ĕ	1 Never Married 2 Married	Armed Forces?	10.	f Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	Black, White	
urs al		۾	3 XWidowed 4 ☐ Divorced	1 □ Yes 2 □ No If Yes, Give X Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify: W	hite
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car y carror & r. & carror & c	9	၀	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street			City or Town, State, 2	Ip Code)
25 E E	9		Gwen Berger - Da	aughter	4385	Americ	an Dr.	#103 Anı	nandale	VA 22003
ges 1 ar for Heal fritern		ì	20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other pla	ce)	Date 20	c. Location - City or	VA 22003 Town, State
Pages tment of tant: If if	1		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State		,	' I	2/2004 7	Washingt	on, DC
permit. Page Department of Important: If	DUCE		21. Signature of Europeal Service License	, 0 1-						uneral Hom
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Physici /Medic Examin	al er	liner	23a. Part1. Enter the disease of complishook, or he if failure. List only one disease or condition resulting in leath) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a conse	quence of):_		neum			Interval Between Onset and Death
cate be executed physician and the burial-transit		dical Examin	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
The Could by T.C. BOX 00100, The law requires that the death certificate be executed ate has been signed by the attending physician and mane 2 should be delached for use as the build-Iransis		hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnance Other (specify)	1		23d. Date of deli Month	very Day Year
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The la		mo						autopsy performe	d? death?	completion of cause of
Cien: T		0	25. Was case referred to medical				26. Place of Dea	th (Check only one)	No 1 □ Yes	2 □ No
ysici ysici is cer		0	examiner? 1 ☐ Yes 2 ☐ No	spital:	ER/Outpatien	nt 3□ DOA O#	1		ce 6 □Other (Spec	cify)
ig Phy ter this		Ľ.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injui Wor		28d. Describe how		
Attending or death.		atle	2 Accident investigation		.,,.,		Yes 2 □ No			
ol or Att s after d li Direct		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Spec.	nome, farm, str ify)	eet, factory, office		28f. Location (Stree City or Town,	et and Number or Ru State)	ral Route Number,
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Functed Director: After this certificate has commissely filled in by the funcard director nade.		edical (29a. Certifier (Check only one) 1 Certifying Physical Check only one) 1 Medical Examin	cian: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or in	n occurred at the til vestigation, in my o	ne, date and place pinion, death occu	, and due to the causerred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To the To the To the		ž	29b. Signature and title of certifier			29c. Licens		29d	. Date signed (Month	n, Day, Year)
			1 -10	win len	7	Di	18767	Z /*	TPRI/ à	2,2004
		Ų	30. Name and ad ress of person who cor	rpleted cause of death (Ite	m 23a) (Type,	Print) WiewD	e, Be	Houide	April &	705
Rec	Stat		31. Date file APRh. 6avry 2004	32. Registrar's Skor	ature	12°				

		1 - For State Registrar	State of Maryla		artment of F			giene Reg. No.	004	10486
Physic		Decedent's Name (First, Middle, Last)	Bruce K. Bu				2. Date of Dea Month April		Year 2004	3. Time of Death 4:00 P. M
/Medi Examii		4a. Facility Name (If not institution, give s 1742 Johnson Str 5. Social Security Number 6. Sex	street and number)		4b. City, Town, or Balti		eath	4c. Cou	inty of Death	
Funeral Director		,	7. Age (in y	rs. last birthday) Yrs.	If Under 1 Year Months Days		in. 8. Date of Birtl (Month, Day Feb. 4,	(, Year)	Cour	place (State or Foreign htry) 71and
e Maryland 8a-f show	Director	10a. State 10b. County Maryland N/A		City, Town or Lo					1	0d. Inside City Limits
with the		1742 Johnson Str	eet.		10f. Zip Code 2123	3O		10g. Citizen U • S	of What Coun	try?
Nore, Maryland 21215-0036 spes 1 and 2 should be tiled within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral		12. Was Decedent Ever in Armed Forces? 1XYes 2 No If Yes, Give V16 Year or Dates:		Was Decedent of H	ispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. F	Race - Americ Black, White, Whi	etc.
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Exem	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12) 12th	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired ker	during most of v	working	16b. Kind of	Business/Ind	lustry
yland ould be fite Mental Hy Marked oth Matic event	To Be		. Burrier			Ma	Name (First, Middle, ary O. Cla	rk		
Mar and 2 sh alth and 27 Is m		19a. Informant's Name/Relationship (Ty) Walter Burrier /	•		ng Address <i>(Street a</i> H ighlan d		Rumal Route Number Baltin			Code) nd 21225
Baltimore, Ma permit. Pages 1 and 2 . Department of Health ar Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	sition (Name of matory or other place Crematory	· 1			n-City or To	wn, State aryland
Balt permit. Departr Imports any inje		21. Signature of Funeral Service License	remisele	she 40	Name and Address	is of Facility (Gonce Fune	eral S	ervice	
Physician	1	23a. Part1. Enter the disease, or combli- shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the de le cause on each line. Due to (or as a cons						670.0	Approximate Interval Between Onset and Death
S8760, crate be executed xBM physician and sine burial-transit	dical Examiner	Sequentially list conditions, it any, leading to immodate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last		equence of):	nellit	mou				4
BOX (ath certif ath certif or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o	etal death 3	Ectopic pregnancy Other (specify)				Date of deliver Month	ry Day Year
Cords, P.O. I w requires that the de been signed by the a should be detached t	ted by Ph	Part II. Other significant conditions con	tributing to death but not r	۸ .	nderlying cause give	in in Part I.	11 0	_		e cause of death?
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his his	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2540 H 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4 □ Nursing	Home 5 Reside	nce 6 🗆 O		
DIVISION C spital or Attending P ours after death. neral Diractor: After t filled in by the funera	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre	eet, factory, office		28f. Location (St. City or Town	reet and Nun , State)	nber or Rural	Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Cartifying Phys (Check only one) 2 Madical Examin	ician: To the best of my k ler: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the tim restigation, in my op	e, date and pla inion, death oc	ce, and due to the ca curred at the time, da	use(s) and nate and place	nanner as sta e, and due to	ted. the cause(s)
7 × 10 × 10 × 10 × 10 × 10 × 10 × 10 × 1	×	29b. Signature and title of certifier	water with		29c. License				ned (Month, D	
541		30. Name and address of person who con			Print)		312 Tem			
Sta Registr		31. Date filed (Month, Day, Year) APR 0 7 2004	32. Registrar's Sig		Son N.					2160

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 10487 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day FRANCES LEOLA BEASLEY APRIL 4, 2004 10:08 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) 9-12-1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 215-18-6083 75 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Exercitive must be notified at Yes 2 No Director BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1039 N. KENWOOD AVENUE 21205 USA or items 23a filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3XWidowed 4 ☐ Divorced BLACK "natural". 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If team 27 is marked other than "na any injury or other traumatic average. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAID HOCHSCHILD KOHN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES WILCOX ELLA MAE MILLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES M. BEASLEY, JR/SON 1039 N. KENWOOD AVE. BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State 4-12-2004 GARRISON FOREST CEM. OWINGS MILLS, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee m 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 ames 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** andiac /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): as the burial-P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Wasan autopsy certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 3 DOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number DO012975

State Registrar

7

31. Date filed (Month, Day, Year) APR 0 7 201 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
YIKORAMPIPH, MD HHTN KENWOOD PVE, BALTO MD 2/224 32. Registrar's Signature

ORIGINAL

				1 - For State RegistrarAMEND ITEM #7	State of M		-				and M		iene _{eg. No.} 2 (ากน	10688
	¥.	Physici	an	1. Decedent's Name (First, Middle, L Graciela			0.7 0.2	Canal				2. Date of Deat Month	th Day	Year	3. Time of Death
		/Medic Examir		4a. Facility Name (If not institution, g						r Location o	f Death	April		004 ov of Death	4:12 A M
		Funeral Director	iei	Suburban Hospita	1	ge (In yrs.	last birthday) 84 Yrs.		Be	thesda	1 24 Hrs.	8. Date of Birth (Month, Day, Sept. 19	Mon	tgome 9. Birthp	ry Nace (State or Foreign Notation)
	*131	pu ,		Usual Residence of Decedent 10a, State 10b, County		100 0	T					3-P17,	, 1, 1, 1		
		after death with the Maryla or Ifems 23a or 28a-1 shov rifrer must be notified at	ctor	,	/A	Toc. Cr	ty, Town or Lo	ocation		Wa	shin	gton		1	0d. Inside City Limits 1 Yes 2 No
		ith the	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Cour	itry?
		s 23a	ral	2801 Quebec St						20008				ted S	
	36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-1 show summatic event, If a Medical Evartinet must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	?] No	1	Was Deced If Yes, spec				cify Yes or No- Rican, etc.)		ce - Americ ack, White, fy: Wh	
	21215-0036	i within 72 hou jiene. r than "natura ir a Medical E	Completed	15. Decedent's (Specify only highest g	Education rade completed)		(Give	dent's Usua kind of wor DO NOT us	k done	durina most		1	16b. Kind of E	Business/Ind	dustry
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	Maryland	ld be filed ental Hyg ked other ic event,	To Be	17. Father's Name (First, Middle, Las Julian		a Gua	rdia			18. Mothe	r's Name	(First, Middle, M	Maiden Sumai	me) (U1	navailable)
	ary	s 1 and 2 should t Health and Mer item 27 is marke other traumatic	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street	and Numbe	r or Rurai	Route Number,	City or Town	, State, Zip	Code)
	2	es 1 and 2 of Health a f item 27 li r other tra		Georgina Canales	-Gex / Dau			0 Jon	es I	Lane;		estown,			
	3altimore,	m 0 .		20a. Method of Disposition 1 Deurial 2 Cremation 3	☐Removal from State	, (Place of Dispo cemetery, crer	matory or of	her plac		pri1	7	20c. Location	- City or To	wn, State
	Ħ	artmer artmer ortant injury		' 4 □ Donation 5 □ Other (Special Signature of Fugeral Service tice	-	Che	esapeal	-			200			sville	e, MD
	Ва	permit. Departn Imports any inju		Stiple Analy		W0038	BZ R	app F	uner	al an	d Cr	emation er Spri	Servi	ces	,
		Physician		23a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final disease or condition	y one cause on each	od the deat line.	h. Do not ent	ter the mode	of dyin	g, such as	ardiac or	respiratory arre	est,	20911	Approximate Interval Between Onset and Death
		/Medical Examiner		resulting in death)	Due to (or a								<u></u>		
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4/2/	Ρ.	that the de ed by the detached	Phy	Part II. Other significant conditions	contributing to death	but not res	ultina in the u	nderlying ca	use dive	en in Part I.		23e. Did tob	acco use con	tribute to the	e cause of death?
A	ords,	w requires that been signed should be dei	ted by									1 □ Ye	V		ably 4 Unknown
GRACIELA	Vital Records		Completed									24a. Was an autopsy perform	/ lad?	prior to con death?	sy findings available appletion of cause of
BAC	Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only one			
3		Phys or this oral di	To To	1 ☐ Yes 2 ☐ No 27. Manner of Dest	1 V Inpati 28a. Date of Inj (Month, Da		ER/Outpatien 28b. Time of		c. Injury	at		e 5 Resider)
5	ion	Attending F r death. sctor: Atter by the funer	atlo	1 Natural 5 Pending 2 Accident investigation	on	ay Year)	Injury	M	Work	k? Yes 2.⊟N			,,		
CANALES	-	al or Attend s after death il Director: ,	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of In building, e	jury - At ho tc. (Specif	ome, farm, stri	eet, factory,	office		28	Bf. Location (Str. City or Town,	eet and Numb State)	er or Rural	Route Number,
JAN		To the Hospital or At within 24 hours after o To the Funeral Direct completely filled in by	Medical (29a. Certifier 1 Certifying P (Check only 2 Medicel Exe	thysicien: To the best miner: On the basis of and manner s	ot exam≀na	wledge, death tion and/or inv	occurred a vestigation,	it the tim	ne, date and pinion, death	place, ar occurred	nd due to the car d at the time, da	use(s) and ma te and place,	anner as sta and due to	ated. the cause(s)
)	To the k within 24 To the f complete	N	29b. Signature and title of certifier	man	, nu	0		~	2766	T	29	d. Date signe	d (Month, D	Pay, Year)
		14		30. Name and add as of perso	•	death (Item	1 23a) (Type,	Print)		UE P		Rol	acvicu	= '	Walter Commencer
	3	Sta Registr		31. Data filed Magin, Day Year, 2004	32. Regist		4	ak	/			7		000	

State of Maryland / Department of Health and Mental Hygiene 2004 10489 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2, 9:20 April 2004 Carlin /Medical Elizabeth Anna 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie | Year | If Under 24 Hrs Mariner Health Care of N. Arunde1 Anne Arundel Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🕮 F Days Hours 7,1927 220-22-9092 77 Mary land Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ? is marked other than "natural", or Iteme 23s or 28s-f show traumatic event, the Medical Examinar must be multiled at Glen Burnie 1 Yes 2 XNo Maryland Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21061 U.S.A. 313 Hospital Drive Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Specify: white 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify. 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home al Hygiene. Homemaker 9 permit. Peges 1 and 2 should be fit Department of Heatth and Mental Hy important: if Item 27 is marked other any injury or other traumails event 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Rice Edward Medinger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 1609 Terrace Drive Westminister, Maryland 21157 James Carlin- son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 4/6/04 Baltimore, Maryland 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 21. Signature of Funeral Service Licenses 6224 Eastern Avenue Baltimore, Maryland 21224 Lier 23a. Part1. Enter the disease, or complications that caus shock, of heart failure. List only one cause on each Do not enter the mode of dying such as cardiac or respiratory arrest Approximate Interval Between and Death Immediate Cause (Final disease or condition erchan **Physician** resulting in death) /Medical to (or as a consequence Examiner 12011 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a G Examiner the death certificate be executed as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physicien Completed by Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year detached for Day 5 ☐ Other (specify) the 9 □Unknown þ The law requires that Part II. Sther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed pe 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 X No should been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy performed? Yes 2 No certilicate 1 Tyes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 XNatural Attending 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation after death. 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number 21684 Doctor and address of person who completed cause of death (Item 23a) (Type, Print)

1. CYRIAC, M.D. 8021 KITCHIR LOWY, PASADRNA, MD ·V·CYRIAC MID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 7 2004 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 3 per FH-C830.04/07/04dhb/ Department of Health and Montel Hygiene C. C. D.

			Amend Item 3 per 1 - State Registrar	er FH G830.	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	ihi nd / Depa <i>Ce</i> a	artmen rtificat	t of H e of L	lealth a Death	and M		jiene (2004	104	90
	Physicia		Decedent's Name (First, Middle Emma L . Coll								2. Date of Dea Month March 3	Day	Year	3. Time of De Unknown	
	/Medic		4a. Facility Name (If not institution		mber)		4b. City.	Town, or	Location of		March 5		ounty of Death		
	Examin	er	7810 Clark		,			Hanov					line Ar		
F	uneral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under	1 Year	If Under		8. Date of Birth			aplace (State or F	-oreign
	irector		215-28-4825	1 □ M 3 (T)F	74	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Feb 9,	1930) MD	intry)	
g	1 -1 5-13		Usual Residence of Decedent		10.0									101111111111111111111111111111111111111	11 2
arylai	t a	_	10a. State 10b. County			ity, Town or Lo	ocation							10d. Inside City 1 ☐ Yes 2	
e X	8a-f	Director	MD Howard			Jessup									***
with ti	Nor 2		10e. Street and Number 7810 Clark Road	067 11-	1 d d TO	-4-4-	10f. Zip				1		en of What Cou	intry?	
eath ,	8 234 High	Funeral	11. Marital Status		edent Ever in t			0794	isoppie Ori	nin? (So	noity Var or No-	US	A I. Race - Amer	ican Indian	
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urs al	la la	þ	3 X Widowed 4 ☐ Divorced	If Yes, Gi Year or D	ve X lates:		1 🗌 Yes	2 X No	Specify:			S	Specify: Wh:	ite	
72 hours after death with the Maryland	natur IIcal	Completed	15. Decedent (Specify only highes			16a. Dece	dent's Usua	al Occupa	ation	t of work	ina	16b. Kind	of Business/I	ndustry	
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1 and	Item 27 other tr		20a. Method of Disposition	- Neice		Place of Dispo	sition (Nar	ne of		APPROXIMATE AND ADDRESS OF THE PARTY OF THE	t Balti Date		ation - City or T		
Pages	or of		1 Burial 2 Cremation		State	cemetery, crei	matory or c	ther place	e) 1				idge, N		
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11	ysician and ledical aminer the prize transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease of Injury that Initiated events resulting in death) Last	b. Due to	(or as a conse	quence of):	Al	/1	FAT	CT	7.0N			Onset and Dea	
death	attending p for use as	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live i	tcome of pregrointh 2 Fet nant at time of own	aldeath 3[⊒Ectopic pi ⊒ Other (sp					23	d. Date of delik	/ery Day Yea	ar
requires that the	been signed by the should be detached	by	Part II. Other significant condition	ens contributing to d	eath but not re	sulting in the u	nderlying o	ause give	en in Part I.			bacco use es 2 🗆		the cause of dea	
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The	s certificate has t lirector, page 2 s	Completed	7.0011	VITCUL	1011/10		101	10			autops perform	med?	prior to death?	ompletion of cause	se of
VILCII	ertific ector.	Be	25. Was case referred to medical examiner?							of Death	(Check only or	18)			
Physi	this c	2	1 ☐ Yes 2 ☑ No			ER/Outpatier			4 🗆 140		me 5 Reside			ify)	
ing P	fter	:00	27. Manper of Death 1 ☑ Natural 5 ☐ Pendin	9	of Injury th, Day Year)	28b. Time o		8c. Injury Work			28d. Describe ha	ow injury	occurred		
To the Hospital or Attending Physician:	ector: by the	Certification:	2 Accident investig 3 Suicide 6 Could i 4 Homicide	not be 28e. Place	e of Injury - At I ing, etc. (Spec	nome, farm, str	M reet, factory		Yes 2		28f. Location (Si City or Town		Number or Rui	ral Route Numbe	r,
he Hospita	within 24 hours after to the Funeral Dir completely filled in	Medical C	(Check only 2 Medical one)		e best of my kn pasis of examin ther stated.	owledge, deat ation and/or in	vestigation	, in my op	oinion, dea	d place, th occurr	and due to the cred at the time, d	ause(s) ar ate and p	nd manner as	stated. to the cause(s)	
Tot	Tot	Σ	29b. Signature and title of certified		1	/	290	c. License	number		2	9d. Date	signed (Month	Day, Year)	
			Leur	um -	Oh	ml	1	100	1171	35		3	-10-	09	
			30. Name and address of person		se of death (Ite	т 23а) (Туре,	Print)	107	1	11:10	20	7):	2	7	
				DINK	5011		FILTER	1 1-4	, Ut	TUNA	= 20	16)		
	Sta	ate	31. Date filed (Month, Day, Year)	Lanes	Registrar's Sign	grure /	20. 1	,							

	1	For State Registrar	State of Maryland / D	epartment of F	lealth and M	Reg	ene 200														
Physician /Medical Examiner	ŀ	David Boyton La. Facility Name (If not institution, give s			r Location of Death	2. Date of Death Month March	Day Yeer 30, 2004 4c. County of Dee														
Funeral Director		20320 Swa11ow Point 5. Social Security Number 213-50-2087 Usual Residence of Decedent	7. Age (In yrs. last birth		nery Villa If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey,)	Montgome (ear) 9. Bin C 1951 Mar	thplace (State or Foreig													
hours after death with the Maryland hours after death with the Maryland at Examiner was be notified at ed by Funeral Director		Maryland Montgome	10c. City, Town	Montgome	ry Villag		g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 🕅 No													
eath with it	1000	10e. Street and Number 20320 Swallow Poil 11. Marital Status	2. Was Decedent Ever in U.S.	10f, Zip Code 20886 13, Was Decedent of H	dispanic Origin? (Spean, Mexican, Puerto	U	nited Sta	tes													
ours after d rai, or item Exerritor	200	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 ሺYes 2 □ No If Yes, Give Viet Nam Year or Dates:Viet Nam Era	1 ☐ Yes 2 🖾 No	Specify:		Black, Whi	hite													
d 2 should be filed within 72 hours after death with the Marith and Mantal Hygiene. Tris marked other than "natural; or items 23s or 28s-f st traumstic event, the Madical Exercitor must be notified. To Be Completed by Funeral Director	Diplete	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Completed) (College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Disablity	during most of worki		6b. Kind of Business N/A	s/Industry													
gas 1 and 2 should be filed within 72 hours after death with the Marylan to f Heath and Mental Hygiene. It of Heath and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Marked Examiner must be notified at or other traumatic event, the Marked by Funeral Director	0	17. Father's Name (First, Middle, Last) Rochester	Zimmerman DuTeil			Jacque1	ine Sacks														
permit. Pages 1 and 2 sho Department of Health and I mportant: if item 27 is ms iny injury or other traums page.		19a. Informant's Name/Relationship (Ty) Carolyn Harris — I	OuTeil (Wife) 18	Mailing Address (Street 040 Chalet	Dr. #103	Germanto	wn, MD 20	874													
permit. Pages 1 and Department of Health Important: if item 27 any injury or other tr 2068.	-	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Chesa	Disposition (Name of r, crematory or other place peak Cremat	ory April	6	Oc. Location - City of Beltsvill														
permit. Depart Import any inj		21. Signature of Funeral Service License	and Mois les	22. Name and Addre Rapp Funer 933 Gist	cal And Cr	emation ver Spri	Services ng, MD 2	0910													
Charles be executed by Science of	Cal	23a. Part Effer the disease, or comblishock, of heart failure. List only or Immediate Cause (Final disease or condition resulting in death) E squentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Cardiorespi Due to (or as a consequence o Due to (or as a consequence o Coronary Ar Due to (or as a consequence o Due to (or as a consequence o	ratory Arm f): tery Diseas f):	cest	respiratory ares		Approximate Interval Between Onset and Death Minutes Years													
The law requires that the death certificate tale has been signed by the attending physic page 2 should be detached for use as the by physician/Medica	ysiciari/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of de Month	olivery Day Year													
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certificate has b		25. Was case referred to medical				24a. Was an autopsy perform	ed? prior to death? ⊠ No 1 □ Ye	utopsy findings availab completion of cause o													
Physician: this certific ral director.	9	evaminer?	lospital: 1 Inpatient 2 ER/Out 28a. Date of Injury 28b. Ti	patient 3 DOA				esidence 6 Other (Specify)													
To the Hospitel or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be a Modical Contribution. To Be Commisted by	ertification	1 (20) Natural 5 Pending 2 Accident investigation 3 Suicide 4 Homicide 6 Could not be determined		ijury Wo M 1□	rk? Yes 2 □No	28f. Location (Stre City or Town,		Rural Route Number,													
4 hours funeral	Medical C		sicien: To the best of my knowledge, ner: On the basis of examination and and manner stated.																		
To the P within 2.	Me	29b. Signature and title of certifier ### Comman - 30. Name and address of person who command in the command i	ompleted cause of death (flam 23a) 5	4	8/35	29	d. Date signed (Mon	nth. Dey, Year)													
24 /\ State	e*	Donna Rinis, M.D.; 31. Date filed (Month, Day, Year) APR 7 2004			sda, MD	20815															

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** John Davis Lerov Apri1 2004 10:00 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F 70 088-54-5820 Yrs. Canáda Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or itama 23a or 28a-f show traumatic evant, the Medical Examiner must be notified at Maryland Montgomery Silver Spring 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3210 N. Leisure World Blvd. #119 20906 United States Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black/White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If itam 27 is markad othar than "nati Elementary/Secondary (0-12) College (1-4or 5+) 0 Never Worked N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Davis Matilda Jones Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type, Print) Lillian Robinson / Sister 3210 N.Leisure World Blvd.#119; Silver Spring, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) April 6, 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ^¹ 4 □ Donation Chesapeake Crematory 2004 Beltsville, MD 21. Signature 22. Name and Address of Facility Rapp Funeral and Cremation Services any M00382 933 Gist Ave., Silver Spring, MD A Dollman 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Esophageal Stricture years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, checaus or i jury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 ☐ Other (specify) ja Pe 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown <u>Hypertension</u> Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atrial Fibrillation has 1 Tes 2 🗆 No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 Σ Other (Specify) Hospice 10 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, Records, P.O.

Division of Vital Hospital or Attanding Physician: within 24 hours a To tha Funaral (

Registrar

and manner stated.

29c. License number D09470 29d. Date signed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

April 3, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugene P. Libre, M.D.; 10400 Connecticut Ave., Kensington, MD

29b. Signature and title of certifier

4 Thomicide

29a. Certifier

Medical

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Month Day Year AGNES P. DRUMGOOLE-SMITH April 2004 01:15a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner UNIVERSITY HOSPITAL BALTIMORE
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. N/A Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛛 🗶 81 Yrs. Director 215-16-7740 14 1922 MARYLAND DEC. Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral, or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Directo MARYLAND N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1512 N MOUNT 21217 Funeral II S S.A.

14. Race - American Indian, filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 22 No
If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced "natural", Completed r than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "I any injury or other traumatic event, the Med ORCE. Elementary/Secondary (0-12) College (1-4or 5+) 8th grade HOUSEKEEPER DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WALLACE CARBERRY TERESA PAYTON 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Stuart Mills Place, Balto., Md., 21228 Dorothy Merritt/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 04-02-04 BALTIMORE, MARYLAND 21. Signature of Faral Service Lians e 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE ROLLIE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ODON ALM /Medical Que to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of): e to (or as Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed and physician at s the burial-t Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No 3 X DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: / 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jayant Hirpara 611 S. Charles St., Baltimore, Maryland 21230 31. Date filed (Month, Day, Year) #32. Registrar's Signature State APR 0 7 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / De State of Maryland / De Registrar	partment of Health and M me C830 4/13/04 tas enificate of Death	•	ne 2004	10495		
ı	Physicia /Medic		Decedent's Name (First, Middle, Last) ROBERT DWIGHT EDWARDS SR		2. Date of Death Month	Day Yeer 01 2004	3. Time of Death 9:00 P M		
	Examin Funeral		4a. Facility Name (If not institution, give street and number) Bon Secours Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death Baltimore y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Deeth N/A 9. Birthp	lece (State or Foreign		
	Director		215-96-6961	Months Days Hours Min.	(Month, Day, Ye Dec. 10 19	973 Mar	yland Od. Inside City Limits		
	th the Maryl or 28a-f eho	Irector	10e. Street and Number	erstown 10f. Zip Code	10g.	Citizen of Whal Coun	1 □ Yes 2 No		
	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. He file in 72 hours after 23a or 28a-f ehow then 21 to marked other than "netural", or items 23a or 28a-f ehow other treumatic event, the Medical Examinational be rediffied at	Funeral Director	3 Candor Court 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 M No	21136 3. Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	U.S.A. 14. Race - Americ Black, White,	etc.		
2-00-0	"netural", or	Ď	3 ☐ Widowed 4 ☐ Divorced If Yes, Give The Year or Dates:	1 ☐ Yes 2 ☒ No Specify: cedent's Usual Occupation ve kind of work done during most of works. DO NOT use retired)	ing 16b	Specify: Whi			
10 6 16 1	illed within Hygiene. other than	Be Completed	12 College (1-40r 5+) WE 17. Father's Name (First, Middle, Last)	elder 18. Mother's Name	(First, Middle, Maid	_			
iar ylar	2 should be and Menta is marked eumatic ev	ToB		Linda Linda White the stand Number or Rura		ty or Town, State, Zip	Code)		
nore, r	permit. Pages 1 and 2 Department of Health a Importent: if Item 27 it any injury or other tre		20a. Method of Disposition 20b. Place of Discometery, Commetery, ommeter, Commete	Candor Court, Reist position (Name of rematory or other place) ill Cemetery 04/06	Date 20c	Md. 21136 Location-City or To Altimore, I			
Daltimor	permit. F Departme importen any injur		21. Signalure of Funeral Service Licensee	22. Name and Address of Facility McCully-Polyniak 237 E. Patapsco A	Funeral H	lome P.A.	21225		
ı	Physician /Medical	1	resulting in death)	on(Cocaine and Heroin)	or respiratory arrest,		Approximate Interval Between Onset and Death		
	Examiner	ner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
,00,	ie be executed /sician and e burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last						
DOX OO	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	B⊟Ectopic pregnancy		23d. Date of delive Month	ry Day Year		
us, r.o	signed by the	þ	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did lobacc	to use contribute to th	e cause of death?		
records,	2 5 8	Completed			24a. Was an autopsy performed 15€ Yes 2 □	24b. Were autop prior to con death?	ssy findings available apletion of cause of		
ा । जावा	Physician: or this certific aral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpalient 2 KER/Outpate 27. Manner of Death 28a. Date of Injury. 28b. Time	of 28c. Injury at		6 □Other (Specify)		
DIVISION	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 6 Results of the point of the building, elc. (Specify) Found: on sidewalk	and Number of Rural ate (in front re City, MD	er or Aural Apule Number front of 1817 Ramsay v. MD				
	the Hospit hin 24 hour the Funera	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medicel Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, dale and place, a investigation, in my opinion, death occurred.	and due to the cause ed al the time, date a	e(s) and manner as sta and place, and due to	the cause(s)		
	with	W	29b. Signature and little of Confider 30. Name and address of person who completed cause of death (Item 23a) (Typ	O.C.M.E.		oril 02, 20			
1	Sta	te	31. Date filed (Month, Day, Year) 1 32. Registrar's Signature	11 Penn Street, Bal	timore, M	laryland 21	1201		
	Registr		APR 0 7 2004	Al s					

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) april Year . 07PM **Physician** Charles Raymond Fulton 2004 /Medical 4b. City. Town, or Location of Death 4c. County of Deeth 4a. Fecifity Name (If not institution, give street and number) Examiner Hospital osedale Baltimore Center If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours MM 2□F 219-22-1731 April 26,1927 Maryland Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be usuified at once. 1 ☐ Yes 2% No Dundalk Baltimore Maryland Direct 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21222 1930 Penhall Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Allines 2 □ No
If Yes, Give
Year or Dates: 1945-46 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No White Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist American Can Company 4 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anastacia Hopkins John Fulton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 6017 Point Pleasant Ave. Daughter Betty Dewey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 4/7/2001 Dundalk, Maryland * 4 □ Donation _ 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Physician /Medical Due to (or as a consequence of): Examiner sease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Smolhing Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Naturel 2 Accident fnjury 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely tilled in by 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RKSOOC 30. Name and addr s of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore MD 21237 Or. Roger Han 31. Date file Month, Day, Year 32. Registrar's Signature State 7 2004 Registrar

DHMH 17 Rev 1/2001

Fulton, Charle

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar AMENDS ITEM 19a PPR 1NF G830 4/13/Overdificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year FITZGERALD Month **Physician** ERRA 10 00PM 2004 APRIL 05 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPITAL HARBOR N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 😿 F 405 09 7583 29, Kentucky Director 86 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mantal Hyglene.
sent if items 72 is marked other than "natural", or Items 23e or 28e-f show ansit if item 27 is marked other than "natural", or other traumatic event, if a Macical Examinational terministic and 1X Yes 2 ☐ No Director N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 3805 Tenth Street 21225 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Weaverly Press Book Binder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Euphamie Tackett Christopher Columbus Carroll ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6234 Chestnut Oak Lane Linthicum, Maryland 21090 Denald Thompson DONALD THOMAS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition Department of h Importent: If its any injury or of once. 12 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland Meadowridge Mem. Park 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses Lecome Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition NFUMONIA **Physician** BILATERAL resulting in death) /Medical Due to (or as a consequence of) Examiner CONGESTIV HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed FIBR and Due to (or as a consequence of) P.O. Box 68760. physician Completed by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, STROKE 2 No 3 Probably 4 Unknown ANEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page 2 DEMENTIA 1 Tes 2 No of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 npatient 1 ☐ Yes 2 No 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital filled 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Janaki APRIL 05 2004 RESDOI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. HANOVER STREET, BALTIMORE, MD 21225 DEEPAK HARBOR HOSPITAL 31. Date filed (Month, Day, Year) APR 0 7 2004 32. Registrar's Signature State souks Registrar

DHMH 17 Rev 1/200

State

Registrar

APR 0 7 2004

RANDY FREEMAN UNK-04-101 04-2189 DAP **Physician** /Medical Examiner

> **Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or items 23e or 28e-f ehow emp injury or other traumatic event, the Medical Exertifier must be notified at once.

Physician /Medical Examiner

To the Hospital or Atlending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atlending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Registrar			ment of Hea ficate of De		Reg	3. No. 2 U U L	1049
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Social Security Number 6. Se	9.17			Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Bi	rthplace (State or For
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De. Street and Number	C/ /		10f. Zip Code		10	g. Citizen of What C	•
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12 th grade		INCH	rploy co	Motherte Ma	e (First, Middle, Ma	ISABLED	
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 10500 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** John W. Groh March 31 2004 11:40 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5200 - 6th Street Baltimore Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 12 M 2 ☐ F Yrs. 219 05 7303 84 18, 1919 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural', or Items 23a or 28a-f show the Mudical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Maryland Anne Arundel Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5200 - 6th Street 21225 U.S. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itel may injury or other traumatic event, the Medical Examinate ans. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 XWidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Paint Company 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Herman Groh Helen Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John H. Groh 2653 Coxneck Road Chester, Maryland 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 4/6/2004 Glen Burnie, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature_of Funeral Service Licensee 4001 Ritchie Highway uc Baltimore, Maryland 21225 mamusuu cume 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ADENU CARLINOMA THE ESUPHAGUS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of). attending physician Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Po Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe PULMONARY OBSTRUCTIVE DISEATE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ÆUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 2 1 ☐ Yes 2 🔀 No 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural 1 🗌 Yes 2 No death. 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide hours after To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) m, nos. D17753 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Vital

Division of

ORIGINAL

32. Registrar's Signature

10 CHURCH ST

BALTIMORE

MJ 2/2 25

K.S. DHARMASENA, MO

31. Date filed (Month, Day, Year)